

RADIATION MACHINE REGISTRATION FOR CHANGES TO REGISTRANT OR MACHINE INFORMATION

[Click here](#) for instructions.

For changes in ownership, use [RH 2261N](#) (New Registrant) or
[RH 2261W](#) (Withdrawal of Registration).

TYPE OF ACTION. Choose all actions that apply. **Complete sections A, F, G, and H for all actions.**

- If changing registrant information, also complete section B.
- If changing registered machine information, also complete section C.
- If removing one or more registered machine(s), also complete section D.
- If adding one or more radiation machine(s), also complete section E.

A: REGISTRANT INFORMATION

Registrant (name of facility, business, or practice)	Registration Number	<input type="checkbox"/> Mammography Provider
Physical Address (street number and name)	City	State Zip Code

B: CHANGES TO REGISTRANT INFORMATION

Provide new or corrected information only. A completed field indicates a change.

Registrant (name of facility, business, or practice)	Business Phone Number
Type of Facility, Business, or Practice (e.g. dental, medical, veterinary, etc.)	<input type="checkbox"/> Mammography Provider <input type="checkbox"/> No Longer a Mammography Provider
Physical Address (street number and name)	City State Zip Code
Mailing Address (street number and name)	City State Zip Code

FOR RADIOLOGIC HEALTH BRANCH USE ONLY

C: CHANGES TO REGISTERED MACHINE INFORMATION

Provide new or corrected information only. A completed field indicates a change.

Registered Machine	Manufacturer		Model	Room Name or Number
Changes (provide new or corrected information only)	Manufacturer		Model	Room Name or Number
	Number of X-ray Tubes, Waveguides, or Electron Guns	Type Code	Additional Information	

FOR RADIOLOGIC HEALTH BRANCH USE ONLY

Registered Machine	Manufacturer		Model	Room Name or Number
Changes (provide new or corrected information only)	Manufacturer		Model	Room Name or Number
	Number of X-ray Tubes, Waveguides, or Electron Guns	Type Code	Additional Information	

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Registered Machine	Manufacturer		Model	Room Name or Number
Changes (provide new or corrected information only)	Manufacturer		Model	Room Name or Number
	Number of X-ray Tubes, Waveguides, or Electron Guns	Type Code	Additional Information	

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D: REMOVING REGISTERED MACHINE(S) Complete and submit [RH 2261W](#) instead if you are no longer in possession of any radiation machines or all radiation machines in your possession have been made incapable of producing radiation.

Registered Machine	Manufacturer	Model	Room Name or Number
Removal Action (check one)	<input type="checkbox"/> This machine is no longer in my possession. <input type="checkbox"/> This machine has been made incapable of producing radiation.		Removal Action Date (mm/dd/yyyy)
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Registered Machine	Manufacturer	Model	Room Name or Number
Removal Action (check one)	<input type="checkbox"/> This machine is no longer in my possession. <input type="checkbox"/> This machine has been made incapable of producing radiation.		Removal Action Date (mm/dd/yyyy)
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Registered Machine	Manufacturer	Model	Room Name or Number
Removal Action (check one)	<input type="checkbox"/> This machine is no longer in my possession. <input type="checkbox"/> This machine has been made incapable of producing radiation.		Removal Action Date (mm/dd/yyyy)
Additional Information			
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E: ADDING MACHINE(S) Do not add machines that you have already registered.

Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	<input type="checkbox"/> Form FDA 2579
Additional Information			
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Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	<input type="checkbox"/> Form FDA 2579
Additional Information			
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Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	<input type="checkbox"/> Form FDA 2579
Additional Information			
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F: FACILITY CONTACT INFORMATION. Enter the individual that a Radiologic Health Branch representative may contact regarding any information provided on this form.

Name	Phone Number	E-mail Address
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G: SIGNATURE OF AUTHORIZED REPRESENTATIVE.

I declare under penalty of perjury under the laws of the State of California that the information submitted on this form and on any attachments is true and correct. I agree to abide by all laws and regulations that pertain to the operation and registration of the radiation machine(s) for which I am applying including but not limited to those laws and regulations governing the establishment, implementation, and maintenance of a radiation protection program.

Name	Title/Position
Signature	Date

H: RECORDKEEPING/SUBMISSION

Submit all pages. Keep a copy for your records. Do not submit multiple copies of the same completed form. No payment is required at this time. **Mail the original** with supporting documents to:

**ATTN: Registration and Certification Support Unit
California Department of Public Health
Radiologic Health Branch
MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414**

For more information, please visit our website at <http://cdph.ca.gov/rhb> or call (916) 327-5106.

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