UTAH DEPARTMENT OF
HEALTH


**UTAH DEPARTMENT OF HEALTH**
**DIVISION OF FAMILY HEALTH AND PREPAREDNESS**
**BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION**

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Version 09/15/2016

# REQUEST FOR AGENCY ACTION/CERTIFICATION APPLICATION - MAMMOGRAPHY

## A. FACILITY INFORMATION

| FACILITY NAME | | | | | |
|---|---|---|---|---|---|
| STREET ADDRESS | | | MAILING ADDRESS | | |
| STREET ADDRESS CONTINUED | | | MAILING ADDRESS CONTINUED | | |
| CITY | STATE | ZIP | CITY | STATE | ZIP |
| PHONE NUMBER | | FAX NUMBER | | FACILITY EMAIL | |
| SUPERVISING PHYSICIAN | | LICENSE NUMBER | | CATEGORY | |
| SUPERVISING PHYSICIAN EMAIL | | | | PHONE NUMBER | |

| TYPE OF FACILITY (CHECK ALL THAT APPLY) | | ACCREDITATION INFORMATION | |
|---|---|---|---|
| ☐ STATIONARY (# OF UNITS) | | ACR ACCREDITATION ISSUE DATE | |
| ☐ MOBILE (#OF UNITS) | | ACR ACCREDITATION EXPIRATION DATE | |
| | | FDA REGISTRATION NUMBER | |
| | | FDA REGISTRATION EXPIRATION DATE | |

## B. ACTION REQUESTED

| | |
|---|---|
| ☐ INITIAL CERTIFICATE | Include fees, application, FDA certificate, ACR certificate, Medical Health Physicist certificate |
| ☐ CERTIFICATE RENEWAL | Include fees, application, FDA certificate, ACR certificate, Medical Health Physicist certificate |
| ☐ CHANGE OF OWNERSHIP | Include agreement, application, fees, FDA certificate, ACR certificate, Medical Health Physicist certificate |
| ☐ CHANGE IN SUPERVISING PHYSICIAN | Include fees, application |
| ☐ CHANGE IN NAME | Include fees, application |

## C. STAFF INFORMATION

| RADIOLOGY TECHNOLOGIST | | LICENSE NUMBER | | CATEGORY | |
|---|---|---|---|---|---|
| MEDICAL (HEALTH) PHYSICIST | | | | | |

## D. OWNERSHIP OF FACILITY/AGENCY

Indicate the type of ownership, including the name and address for each.

◯ Individual (Also include documentation to verify citizenship) ◯ Corporation ◯ Partnership ◯ Limited Liability Corporation

◯ Other (Describe)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| OWNERSHIP NAME | | | | PHONE NUMBER | | | |
| STREET ADDRESS | | CITY | | STATE | | ZIP | |

## E. OFFICERS/OWNERS OF FACILITY/AGENCY

Indicate the percentage of ownership interest of the officer, member of the board of directors, trustees, stockholders, partners or other persons who have greater than 25% interest in the facility. Add additional pages if necessary.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| OWNER NAME | | TITLE | | PERCENT OF OWNERSHIP | | | |
| STREET ADDRESS | | CITY | | STATE | | ZIP | |
| OWNER NAME | | TITLE | | PERCENT OF OWNERSHIP | | | |
| STREET ADDRESS | | CITY | | STATE | | ZIP | |
| OWNER NAME | | TITLE | | PERCENT OF OWNERSHIP | | | |
| STREET ADDRESS | | CITY | | STATE | | ZIP | |

## CERTIFICATION OF UNDERSTANDING

I understand this request constitutes a Request for Agency Action as specified in Utah Code Annotated 63G-4 and serves as the formal document upon which a certification decision will be based. I agree to abide by the rules promulgated by the State of Utah for this category of health care facility and do hereby state that the information provided on this application is true to the best of my knowledge and belief.

I agree to allow authorized representatives of the Department of Health upon presentation of proper identification to enter the facility at any reasonable time without a warrant and to review facility records and documents as necessary to ascertain compliance with State certification law and rules pursuant to Section 26-21a-203.

| | | | |
|---|---|---|---|
| NAME | | TITLE | |
| SIGNATURE | | DATE | |

Please include, or make arrangement for, submission of the following documents with your application:

1 Make checks payable to the Utah Department of Health.

2 Personnel: (Provide the following information):
  * Physician Supervisor: Name and Utah license number;
  * Radiology Technologist: Name and Utah license number;
  * Medical (Health) Physicist: Name; the Medical (Health) physicist must be approved by the Department of Environmental Quality.

3 Provide a copy of documentation issued by the FDA showing that the FDA has approved mammography equipment and that radiation safety practices comply with FDA requirements.

4 Provide a copy of the ACR and FDA certificates.

**Note: This request for Agency Action/Certification Application shall be considered complete only upon submission of this form, the appropriate licensing fee, required documentation, and the applicable local and state clearances. Failure to submit a complete packet prior to the start of operation or expiration of an existing certificate will result in appropriate sanction as provided for in Utah Code Annotated 26-21 et seq and Utah Department of Health rules.**