OVERDUE NOTICE

Annual Fee for Radiation Emitting Equipment

County No. **55**
Registration No. **5555** Licensee/Registration Number

This Space for Dept. Use Only
PLU2706

Attention: John Doe
JOHN DOE CHIROPRACTIC Facility/Licensee/Registration Name
P.O. BOX **555**

LINCOLN, NE **68508-6214**

Billing Information:

Lincoln NE 68508-6214

Fee Calculation

Individual Machine Fee

1	106	Podiatric Diagnostic	$70.00

TOTAL # Machines	# Tubes	# Panographic Tubes
1	1	0

Total Fee = $70.00

* See Appendix 018A of NAC 1-018

Total Fee was due on July 31, 2015.

PLEASE PAY IMMEDIATELY

Please remit by check or money order, payable to 'Nebr. Department of Health & Human Services', and INCLUDE THIS INVOICE & THE COMPLETED ANNUAL RENEWAL WITH YOUR PAYMENT to assure proper credit to your account.

Name (Type or Print) ____________________ Signature ____________________

Title ____________________ Date ____________________

Please direct all correspondence regarding this billing and registration to:

DHHS, Division of Public Health
X-Ray Registration Program
P.O. Box 95026
Lincoln, NE 68509-5026
(402) 471-0563

05/05/2016

Example of Annual Renewal For Radiation Emitting Equipment begins on page 2

Annual Renewal for Radiation Emitting Equipment

Please verify the accuracy of the enclosed information. Make any necessary changes, additions or deletions; sign and date the renewal and return ALL pages in the enclosed envelope.

County No | **55** | Licensee/Registration Number > **Registration No** | **5555**

1. Name of Facility: **John Doe Chiropractic** < Facility/Licensee/Registration Name

2. Location of Radiation Source(s): **P.O. Box 555**
Lincoln, NE 68508-6214

3. Billing Information: **P.O. Box 555**
Lincoln, NE 68508-6214

4. Phone Number: **(555) 555-5555**

5. E-Mail: **johndoe@johndoe.com**

6. Owner(s)/User/ Possessor of Radiation Source (s): **John Doe**

7. Person Responsible for Radiation Protection: **John Doe**

1. If the information is accurate or the changes are minor (name, address, etc.), please pay the fee listed. Upon receipt of the payment, a Certificate of Registration will be mailed to you.

2. Make all changes on the form in RED. Changes to equipment may necessitate recalculation of fees.

3. Please remit by check or money order, payable to 'Nebr. Department of Health & Human Services', and INCLUDE THIS DOCUMENT WITH YOUR PAYMENT to assure proper credit to your account.

4. If you no longer own or possess the radiation generating equipment listed on this form, please indicate the disposition of the equipment (i.e., trade-in, dismantled, sold to ______________________).

NOTE - 180 NAC 1 002.09 Report of Changes. The registrant shall notify the Agency in writing within thirty (30) days of any change which would render the information contained in the application no longer accurate.

Title 180, Control of Radiation Regulations, Regulatory Guides, X-ray Checklists, Radiation Control Act, etc may be obtained thru the Radiation Control Web Site at: www.dhhs.ne.gov/rad

Please direct all correspondence regarding this billing and renewal to:

DHHS, Division of Public Health
X-Ray Registration Program
PO Box 95026
Lincoln, NE 68509-5026
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John Doe Chiropractic | 55 | 5555

List each machine on a separate line.

Machine Number / Type	Number of Tubes	Manufacturer	Model Number	Serial Number	Date Installed	Date Manufactured	Control Location
1 / 101	1	DRGEM	XCSD - R1	PIC14B1052	03/04/2015	11/01/2014	

Fee Calculation

Individual Machine Fee

1	101	Medical Diagnostic X-Ray General (Radio)	$70.00

TOTAL # Machines	# Tubes	# Panographic Tubes
1	1	

Total Fee = $70.00

* See Appendix 018A of NAC 1-018

Total Fee is due on or before May 31, 2017.

Make Check payable to Dept. of Health and Human Services.
*****Include this document with your payment******

CITIZENSHIP ATTESTATION:

☐ **Check this box if it is not necessary to complete the Attestation part of this application below if the application is for a corporation or other separate legal entity. Explain why: (Example: corporation, partnership, State entity etc.)**

____

OR

If the entity is owned by an individual, complete the United States Citizenship Attestation Form below.

UNITED STATES CITIZENSHIP ATTESTATION FORM

For the purpose of complying with Neb. Rev. Stat. . §§. 4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States

OR

☐ I am a qualified alien under the the Federal Immigration and Nationality Act, my Immigration status and alien number are as follows: ____ and I am providing a copy of my USCIS documentation.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

________________________________ ____ ____________

Name (type or print first, middle, last) Signature Date

Certification

The applicant and/or any official executing this document on behalf of the applicant named certify that this application is prepared in conformity with the Nebraska Department of Health and Human Services Regulation and Licensure, Regulations for the Control of Radiation - Ionizing and that all information contained herein, including any supplements attached hereto, is true and correct to the best of our knowledge.

Name (Type or Print)	Signature
Title	Date

05/10/2016