

RADIATION SOURCE REGISTRATION NEW APPLICATION

PURPOSE

This form is to be used to apply to register a radiation source under the *Radiation Protection Act 2006* (the Act).
You can access the Act and its regulation at www.legislation.act.gov.au.

PRIVACY

The collection of personal information is required by this form for the purposes of registering a radiation source under the Act.
The Health Protection Service (HPS) prevents any unreasonable intrusion into a person's privacy in accordance with the *Privacy Act 1988* (Commonwealth).

HEALTH PROTECTION SERVICE CONTACT INFORMATION

Trading Hours: 9.00am – 4.30pm Monday to Friday

Website: www.health.act.gov.au/hps	General Enquires: (02) 6205 1700	Email Address: hps@act.gov.au	Fax Number: (02) 6205 1705
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INSTRUCTIONS FOR COMPLETION & IMPORTANT INFORMATION

The registration is issued to the owner of the radiation source, who is the person(s) who will have the overall responsibility for the radiation source, including responsibility for any contraventions of the Act.

Accordingly:

- (1) Trusts will not be registered. Companies operating as trustees for a trust will be registered in the company name only.
- (2) Applications listing a partnership as the owner will not be accepted. If the source is owned by a partnership, one or more of the individuals in the partnership will need to be listed.
- (3) Parts B and C of this application form must be completed separately for each individual listed as an owner. Extra copies of Parts B and C are available at www.health.act.gov.au/hps or by contacting the HPS.

- In order to register a source, a company or individual must also hold a licence allowing possession of the source.
- Further information regarding the registration process, including an information sheet is available on the HPS website www.health.act.gov.au/radiationsafety.
- The ARPANSA Radiation Protection Series (RPS) publications, including the National Directory for Radiation Protection, are available online at: <http://www.arpansa.gov.au/publications/Codes/rps.cfm>.
- Complete this form using a black or blue pen and return with the required fee (see page 8).
- Declaration on page 7 must be signed.

Is the registration to be issued to a Corporation (a Company, Incorporated Association, Government agency or a Registered Charitable Organisation)?

- YES Complete PARTS A, C, D and E** of this application. NB: Trusts or Partnerships will not be registered. Companies operating as trustees for a trust will be registered in the Company name only.
- NO Complete PARTS B, C, D and E** of this application. Separate details must be completed for each individual listed as an owner.





Confirmation of identity will need to be produced either:

1. In person at the Health Protection Service office; or
2. By submitting certified copies via the post/email/fax to the HPS office.

TRANSLATING AND INTERPRETING SERVICE

A language assistance service is available by phoning the Translating and Interpreting Service (TIS) on 13 14 50.

COMPLETED FORMS AND PAYMENT TO BE RETURNED

 In Person: Health Protection Service 25 Mulley Street HOLDER ACT 2611	 By Post: Health Protection Service Locked Bag 5005 WESTON CREEK ACT 2611	 By Fax: (02) 6205 1705 <i>If the application is faxed or emailed, please do not post the original.</i>	 By Email: hps@act.gov.au
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CHECKLIST**If applying as an INDIVIDUAL**

<input type="checkbox"/>	Part B completed and signed: Ownership details for an individual (one copy for each owner)
<input type="checkbox"/>	Part C complete: Proof of identification (one copy for each owner)
<input type="checkbox"/>	One form of current photographic identification (for each signatory) presented in person at the Health Protection Service OR One form of current photographic identification (for each signatory) sighted and certified by an authorised witness for each signatory.
<input type="checkbox"/>	Part D completed: Registration details
<input type="checkbox"/>	Attached copies of plans and other documentation (as required)
<input type="checkbox"/>	Part E completed: Source Details
<input type="checkbox"/>	Declaration signed (page 7)
<input type="checkbox"/>	Attached payment (page 8)

If applying as a CORPORATION

<input type="checkbox"/>	Part A completed and signed: Ownership details of a company
<input type="checkbox"/>	Attached current company extract (issued in last 30 days) by the Australian Securities and Investment Commission (ASIC)
<input type="checkbox"/>	Part C complete: Proof of identification (for company agent)
<input type="checkbox"/>	One form of current photographic identification presented in person at the Health Protection Service OR One form of current photographic identification sighted and certified by an authorised witness for each signatory.
<input type="checkbox"/>	Part D completed: Registration details
<input type="checkbox"/>	Attached copies of plans and other documentation (as required)
<input type="checkbox"/>	Part D completed: Registration details
<input type="checkbox"/>	Declaration signed (page 7)
<input type="checkbox"/>	Attached payment (page 8)

PART A – APPLICANT DETAILS FOR A COMPANY (Do NOT complete if you are applying as an individual)									
A copy of the Company’s current extract (<i>issued within the previous 30 days</i>) from the Australian Securities and Investment Commission (ASIC) <u>must be attached.</u>									
COMPANY NAME									
AUSTRALIAN COMPANY NUMBER (A.C.N.) - Leave blank if an Incorporated Association, Government agency or a Registered Charitable Organisation									

PART B – APPLICANT DETAILS FOR AN INDIVIDUAL (Do NOT complete if you are applying as a company)		
Note for Multiple Owners: (for example partnerships) Copies of Part B are available at www.health.act.gov.au/hps or by contacting the HPS.		
TITLE (Mr, Ms)	GIVEN NAMES	FAMILY NAME

PART C - APPLICANT ADDRESS (If applying as a company the registered company address must be provided)		
<i>(Property Name, Unit, Flat Number, Street Number, Street Name)</i>		
CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

PART C - APPLICANT POSTAL ADDRESS (If different to above applicant address)		
CITY / SUBURB / TOWN	STATE / TERRITORY	POSTCODE

BUSINESS HOURS PHONE NUMBER	MOBILE NUMBER
FAX NUMBER	EMAIL ADDRESS

DECLARATION
<p>I, _____, confirm that the information supplied on this page is true and accurate and understand that the provision of false or misleading information is an offence.</p> <p>Signature : _____ <i>(For Companies - Signature of authorised agent only)</i></p> <p>Position Title (Companies): _____</p> <p>Date: / /</p>

PART C – PROOF OF IDENTIFICATION (Must be completed for a company (by the registered agent) and individual applicant)

One form of current photographic identification sighted and certified by an authorised witness must be provided for each signatory in Parts A or B.

A list of authorised witnesses for true and correct copy can be found at:
<http://www.ag.gov.au/Publications/Pages/Statutorydeclarationsignatorylist.aspx>

The witness should include the following text on a certified copy:

EXAMPLE

CERTIFIED TRUE COPY OF THE ORIGINAL
 I certify that this is a true and accurate copy of the original document sighted by me.
 Signed: _____ Dated: _____ Authority to sign: _____ Phone: _____

ACCEPTABLE FORMS OF PHOTOGRAPHIC IDENTIFICATION – Examples below

- Driver’s licence
- Proof of age or identity card issued by a State/Territory
- Passport

FORMS OF IDENTIFICATION PROVIDED

Type	Number	Expiry Date	Certified Copy Attached
			<input type="checkbox"/>
			<input type="checkbox"/>

Note for Multiple Owners: (for example partnerships) Copies of Part C are available at www.health.act.gov.au/hps or by contacting the HPS.

PART D – REGISTRATION DETAILS - (Must be completed)

DETAILS OF LICENCE TO POSSESS A RADIATION SOURCE

Existing Licence to Possess RS ___/____ **OR** A new application for a Licence to Possess has been submitted separately in the name of _____

SOURCE LOCATION

BUSINESS/TRADING NAME:

SPECIFIC LOCATION: (Building Name, Room No/Name, Department area, Building etc)

SUBURB: _____ **STATE:** _____ **POSTCODE:** _____

CONTACT DETAILS

CONTACT PERSON:

PHONE (bh): _____ **MOBILE:** _____ **FAX:** _____

ADDRESS:

SUBURB: _____ **STATE:** _____ **POSTCODE:** _____

SOURCE TYPE (select the radiation source type to be registered)

- X-ray Apparatus Include more detailed information in section 1 on **Page 6**
- Sealed Radiation Source Include more detailed information in section 2 on **Page 6**
- Apparatus Incorporating Sealed Radiation Source Include more detailed information in section 3 on **Page 6**
- Accelerated Particle-beam Apparatus Include more detailed information in section 4 on **Page 7**
- Radioactive Material Include more detailed information in section 5 on **Page 7**

USE CATEGORY (Please ✓ only one category)

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Dental (General) | <input type="checkbox"/> Medical | <input type="checkbox"/> Veterinary (General) |
| <input type="checkbox"/> Dental (Specialist) | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Veterinary (Specialist) |
| <input type="checkbox"/> Research | <input type="checkbox"/> Security | <input type="checkbox"/> Industrial (specify) _____ |
| | | <input type="checkbox"/> Other (specify) _____ |

USE SUBCATEGORY (Please ✓ only one category)

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Therapeutic | <input type="checkbox"/> Quality Assurance |
| <input type="checkbox"/> Forensic | <input type="checkbox"/> Analytical | |
| <input type="checkbox"/> Other (specify) _____ | | |

INSTALLATION DETAILS

Supplier Information
 Supplier Name: _____
 ACT Licence Number: RS ___/____
 Supply Date: ___/___/___

Installer Information
 Installer Name: _____
 ACT Licence Number: RS ___/____
 Install Date: ___/___/___

PLANS AND OTHER DOCUMENTATION

Radiation Management Plan <i>(required for all new applications)</i>	<input type="checkbox"/> Included	<input type="checkbox"/> Pending	<input type="checkbox"/> N/A
Shielding Plan <i>(required for new or renovated premises)</i>	<input type="checkbox"/> Included	<input type="checkbox"/> Pending	<input type="checkbox"/> N/A
Security Plan <i>(required for security enhanced sources only)</i>	<input type="checkbox"/> Included	<input type="checkbox"/> Pending	<input type="checkbox"/> N/A

Registration will not be granted until all required documentation has been received for above section.

PART E - SOURCE DETAILS - (Fill out the relevant section ONLY to correspond with Source Type on page 5)

X-ray apparatus – Section 1

Description of Source: _____

Intended Use/Principal Function: _____

Apparatus

Manufacturer: _____ Model: _____ Serial No: _____

Tube Head

Manufacturer: _____ Model: _____ Serial No: _____

Tube Housing

Serial No: _____ Model: _____ Manufacturer: _____

Max Current (mA): _____ Max Tube Voltage (kVp): _____

Fixed Mobile Portable Continuous Exposure: Yes No

Sealed Radiation Sources - Section 2

Description of Source: _____

Intended use/Principal function: _____

Manufacturer: _____ Model: _____

Radionuclide: _____ Source Serial No: _____

Source Activity: _____ Calibration Date: _____

Apparatus Incorporating a Sealed Source – Section 3

Description of Source: _____

Intended use/Principal function: _____

Manufacturer: _____ Model: _____

Device Serial No: _____

Radionuclide: _____ Source Serial No: _____

Source Activity: _____ Calibration Date: _____

End of Working Life *(where applicable)*: _____

Accelerated Particle-beam Apparatus – Section 4

Description of Source: _____
 Intended use/Principal function: _____
 Manufacturer: _____ Model: _____
 Serial No: _____
 Type of Accelerator: _____
 Accelerated Particle(s): _____
 Maximum Energy (MeV): _____
 Types of Radiation Produced: _____

Radioactive Material – Section 5

<i>Radionuclide</i>	<i>Maximum Activity on premises at any one time</i>	<i>Maximum activity in use at any one time</i>	<i>Intended Use:</i>

Separate page attached with more radionuclide details.

DECLARATION

I declare that I am authorised to supply all the information above; that all the information supplied on this form is true and correct; and that there are necessary records and/or documentation to support this application.
 I understand that failure to submit all required information and documentation may delay my application and that the provision of false or misleading information may be a criminal offence.

NAME: _____ **POSITION:** _____
SIGNATURE: _____ **DATE:** _____

PAYMENT

REGISTRATION DURATION

Please tick (✓) your desired duration

1 Year - \$232
 2 Years - \$464
 3 Years - \$696

Please complete Payment Method below.

PAYMENT METHOD

Please tick (✓)

Cash
 Cheque (please make payable to the Health Protection Service)
 Credit card (please complete details below)

CREDIT CARD DETAILS - IF PAYING BY CREDIT CARD

I agree to this credit card being debited the required fee and the credit card details being destroyed once the transaction is processed.

GST is not applicable under section 81-5 of the A New Tax System (Goods and Services Tax) Act 1999.

Card Holder's Name: _____

Card Holder's Signature: _____ Date: ____/____/____

Daytime Phone No: _____

Card Number (Visa or MasterCard only)	Expiry Date
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>