



RADIATION SOURCE VENDOR REGISTRATION

Radiological Health Program (907) 334-2107

Vendor Mailing Address: VENDOR NAME CONTACT PERSON ADDRESS CITY, STATE, ZIP EMAIL ADDRESS	Business Address: FACILITY NAME CONTACT PERSON ADDRESS CITY, STATE, ZIP	Mail to: STATE PUBLIC HEALTH LABORATORIES RADIOLOGICAL HEALTH PROGRAM 5455 Dr. Martin Luther King Jr. Ave Anchorage, Alaska 99507-1270 Check Appropriate Box/es <input type="checkbox"/> Medical Imaging <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Industrial <input type="checkbox"/> Educational <input type="checkbox"/> Other (Specify) _____ Telephone <input type="text"/>
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VENDOR CONTACT INFORMATION

Individual Responsible for Radiation Safety: _____
Telephone No. _____ Fax No. _____
E-mail Address: _____ Internet Web Address: _____
Describe the radiation device(s), material(s), or service(s) your company intends to sell, service, calibrate, evaluate, or distribute in Alaska:

CERTIFICATION

This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

Print Authorized Name _____ Date _____
Authorized Signature _____
Title _____

NOTE: If products require a federal license, such as a radioactive materials license from the U.S. Nuclear Regulatory Commission, a copy of that license must accompany this application.

OFFICIAL USE ONLY:	<input type="checkbox"/> Documentation Received	<input type="checkbox"/> Certificate Sent - Date
	<input type="checkbox"/> Action Complete	

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