RADIATION MACHINE REGISTRATION FOR
WITHDRAWAL OF REGISTRATION

Click here for instructions.

A: REGISTRANT INFORMATION

Registrant (name of facility, business, or practice)		Registration Number	☐ Mammography Provider
Physical Address (street number and name)	City	State	Zip Code

B: REASON FOR WITHDRAWAL See instructions for which box to check.

☐ Registrant is no longer in possession of any radiation machines.
☐ All radiation machines that the registrant is in possession of have been made incapable of producing radiation.

C: 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.

Name	Title/Position	Signature
E-mail Address	Phone Number	Date

D: RECORDKEEPING/SUBMISSION. Keep a copy for your records. Do not submit multiple copies of the same completed form. **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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