GOVERNMENT OF BERMUDA
Ministry of Health and Seniors
Department of Health

Application Form

Ionizing and Non-Ionizing Radiation License (Form RF01)

Section 1 : Applicant

Type of Request

☐ **Construction** ☐ **Renewal** ☐ **Operating to Commission**

☐ **Decommissioning** ☐ **Routine Operation (Amendment)**

Current License Number:

Language of License

☐ **English** ☐ **Other:**

Applicant Information

Applicant:

Office Address:

Street: Parish: Postal Code:

Mailing Address (If Different From Above):

Street: Parish: Postal Code:

Access to License Information

Is any part of this application subject to a request for exemption from the PATI policy on public access to licensing information?

☐ ☐

(Note: If Yes, attach details of request for exemption)

Contact Person For Billing

Name: **Title:**

Telephone Number: **Fax Number:**

Email:

Proof of Legal Status

Business Number:

☐ **Incorporated Company**

☐ **Public Institution (Specify the Enabling Legislation [Act]):**

☐ **Sole Proprietorship**

Append proof of applicant's incorporation, registration or charter (specify the appendix name and number).

Section 2 : Licensed Use Type, Activities and Locations

Licensed Use Types

Indicate only one prescribed equipment use type. A separate application is needed for each.

1. DENTAL

☐ **X-ray Intra-Oral** ☐ **Cone beam computed tomography**

☐ **2D Panoramic unit** ☐ **3D Panoramic unit** ☐ **Handheld X-ray unit**

Licensed Activities

Check as many activities as you intend to conduct in association with the nuclear substances that are associated with or arise from your selected prescribed equipment use type:

☐ **Store** ☐ **Transfer** ☐ **Import** ☐ **Export**

☐ **Other:**

Section 3 : Prescribed Equipment

Class II Prescribed Equipment (If more space is required, please submit on a separate sheet.)

A. Medical system

Manufacturer	Model Name & Number	Certificate Number	Serial Number (If Available)	Location (Room Number)

Section 4: Radiation Safety Policies and Procedures

As Low As Reasonably Achievable (ALARA)

Append a copy of your organization's policies and procedures to ensure that radiation exposure is ALARA.

Appended as:

Action Levels

Append a copy of your organization's policies and procedures regarding action levels.

Appended as:

Worker Qualifications, Experience, Training and Authorization

Append a copy of your organization's policies and procedures which state that only trained workers may handle nuclear substances and attach a detailed description of the qualifications of workers and the proposed in-house training program.

Appended as:

Personal Dose Monitoring

Append a copy of your organization's policies and procedures for external dose monitoring.

Appended as:

Section 5: License Renewals

(to be completed only when renewing an existing license)

Radiation Dose Summary

Append a report summarizing the past year's external (TLD) radiation dosimetry results for all of the license's monitored workers.

Appended as:

Section 6: Facility Planning and Design Parameters

Site Control

Append proof of ownership or authorization to build on the proposed site and a description of the facility restrictions and public notification program.

Appended as:

Facility Plans and Drawings

Append the plans and elevation drawings with the required information.

Appended as:

Description, Occupancy and Classification of Adjacent Areas

Append the classification and occupancy factors of the adjacent areas based on the planned use of each area. Include the areas above and below the treatment room.

Appended as:

Section 7: Safety System Requirements

Warning Lights

Append a detailed description of the warning lights and indicate their locations on the plans of the treatment

room.

Appended as:

Radiation Warning System

If applicable, append a detailed description of the radiation warning system and its function. Indicate its location on the plans of the treatment room.

Appended as:

Emergency Off Buttons

Append a description of the design and function of the emergency stop buttons both inside and outside the treatment room. Indicate their locations on the plans of the treatment room.

Appended as:

Beam Stops

If applicable, append a description of the methods used to limit the primary beam orientation.

Appended as:

Viewing System

Append a description of the viewing system used to monitor the patient during treatment.

Appended as:

Warning Signs

Append a description of the size and location of the radiation warning signs to be posted at the facility.

Appended as:

Section 8: Legal Signing Authority

Signing Authority

I accept the designation of Signing Authority and certify that all information submitted is true and correct to the best of my knowledge. I understand that all statements and representations made in this application and on supplementary documentation are binding on the applicant.

Name: **Title:**

Date: **/** **/** **Signature:**

DD MM YYY

Applicant Authority

I certify that all statements and representations made in this application and on supplementary pages are binding on the applicant.

Name:	**Title:**
Date: / / DD MM YYY	**Signature:**

Mail the completed application form, together with all relevant documentation to:

Bermuda Department of Health
Metro Building
Occupational Safety & Health
6 Hermitage Road
Devonshire, FL 01

Telephone: 441-278-5333
Fax: 441-236-1941
Email: osh@gov.bm