



# RADIATION PRODUCING MACHINE REGISTRATION FORM

Name of applicant (degree): \_\_\_\_\_ Date: \_\_\_\_\_

Faculty rank: \_\_\_\_\_ Dept.: \_\_\_\_\_

Office/room #: \_\_\_\_\_ Mail code: \_\_\_\_\_ Phone: \_\_\_\_\_

This form is for Principal Investigators requesting an xRUA which will authorize you to work with x-ray producing machinery (x-ray diffraction/crystallography units). This form can also be used to add a new machine to the TSRI inventory as required by California Department of Health Services, Radiological Health Branch.

## A. New Equipment

Add new equipment by providing the information below:

### TYPE OF UNIT

- Accelerator
- Cabinet X-ray
- Electron Microscope
- X-ray Diffraction
- X-ray Fluorescence

Other:

### DESCRIPTION OF UNIT

|               |       |          |         |       |         |       |
|---------------|-------|----------|---------|-------|---------|-------|
| Manufacturer  | _____ | Voltage  | Maximum | _____ | Routine | _____ |
| Model         | _____ | Current  | Maximum | _____ | Routine | _____ |
| Serial Number | _____ | Location |         | _____ |         | _____ |

## B. Description of Proposed Use

Briefly describe how this equipment will be used.

## C. Previous Experience

Provide information concerning the investigator's experience with this or similar equipment.

## D. Authorized Users

List the staff members who will be working with the equipment. Remove individuals who are no longer authorized to use this equipment.

|                              |                                 |                   |       |                              |                                 |                   |       |
|------------------------------|---------------------------------|-------------------|-------|------------------------------|---------------------------------|-------------------|-------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> DELETE | NAME: Last, First | _____ | <input type="checkbox"/> ADD | <input type="checkbox"/> DELETE | NAME: Last, First | _____ |
| <input type="checkbox"/> ADD | <input type="checkbox"/> DELETE | NAME: Last, First | _____ | <input type="checkbox"/> ADD | <input type="checkbox"/> DELETE | NAME: Last, First | _____ |

Applicant/xRUA Holder: \_\_\_\_\_ Date: \_\_\_\_\_  
[SIGNATURE]

|                      |  |              |
|----------------------|--|--------------|
| FOR EH&S USE ONLY    | Issued an xRUA? <input type="checkbox"/> YES <input type="checkbox"/> NO | xRUA#: _____ |
| RSO Signature: _____ | Date: _____  |              |