

Service Provider Renewal Registration Application

Applicant Information

Name: _____
First _____ Middle Initial _____ Last _____
Home Address: _____
City/State/Zip: _____
Phone #: _____ Email: _____

Employment Information

Company Name: _____
Business Address: _____
City/State/Zip: _____
Business Phone #: _____ Email: _____

Credential (according to MN Statute 144.121) (Please check all that apply. Additional documentation is required for certain credentials, as noted below.)

- Service Technician
- Vendor
- Qualified Medical Physicist (Credentials required)
- Qualified Expert (Credentials required)
- Physicist Assistant (Physicist Assistant Application and Supervisory Attestation form required)

Experience and Training

Experience (Please check all that apply. Use additional paper if necessary.)

Years of Experience _____

<input type="checkbox"/> Automatic Processors	<input type="checkbox"/> Bone Densitometry	<input type="checkbox"/> C-arms	<input type="checkbox"/> Computed Radiography
<input type="checkbox"/> CT Installation	<input type="checkbox"/> CT Physics Testing	<input type="checkbox"/> Dental Extraoral	<input type="checkbox"/> Dental Intraoral
<input type="checkbox"/> Digital	<input type="checkbox"/> Fluoroscopic	<input type="checkbox"/> Industrial	<input type="checkbox"/> Mammographic
<input type="checkbox"/> Podiatry	<input type="checkbox"/> Radiographic	<input type="checkbox"/> Shielding Plans	<input type="checkbox"/> Radiation Surveys
<input type="checkbox"/> Dental CBCT	<input type="checkbox"/> Medical CBCT	<input type="checkbox"/> Superficial Therapy	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Other (list) _____			

Training (List specific training, providers and dates. Use additional paper if necessary. Physicist Assistants must provide documentation of the supervising qualified expert or qualified medical physicist.)

Manufacturers

<input type="checkbox"/> Agfa	<input type="checkbox"/> Axtech	<input type="checkbox"/> Belmont	<input type="checkbox"/> Bennett	<input type="checkbox"/> Continental
<input type="checkbox"/> CPI	<input type="checkbox"/> Del Medical	<input type="checkbox"/> Excel	<input type="checkbox"/> Fischer	<input type="checkbox"/> Gendex
<input type="checkbox"/> General Electric	<input type="checkbox"/> Hologic	<input type="checkbox"/> Icat/New Tome CT	<input type="checkbox"/> Instrumentarium	<input type="checkbox"/> Kodak
<input type="checkbox"/> Konica	<input type="checkbox"/> Lorad	<input type="checkbox"/> Lumix	<input type="checkbox"/> Midwest	<input type="checkbox"/> Mini X-ray
<input type="checkbox"/> Norland	<input type="checkbox"/> OEC	<input type="checkbox"/> Phillips	<input type="checkbox"/> Picker	<input type="checkbox"/> Planmeca
<input type="checkbox"/> Prodigy	<input type="checkbox"/> Progeny	<input type="checkbox"/> Quantum	<input type="checkbox"/> Ritter	<input type="checkbox"/> Schick
<input type="checkbox"/> Sedecal	<input type="checkbox"/> Siemens	<input type="checkbox"/> Sirona	<input type="checkbox"/> SS White	<input type="checkbox"/> Summit
<input type="checkbox"/> Toshiba	<input type="checkbox"/> Traceray	<input type="checkbox"/> Transworld	<input type="checkbox"/> Universal	<input type="checkbox"/> Weber
<input type="checkbox"/> Other (list) _____				

Services

<input type="checkbox"/> Diagnostic	<input type="checkbox"/> Equipment Performance Evaluations	<input type="checkbox"/> Industrial
<input type="checkbox"/> Installation Calibration	<input type="checkbox"/> Installation of Equipment	<input type="checkbox"/> Quality Control Tests
<input type="checkbox"/> Repairing of Equipment	<input type="checkbox"/> Shielding Plans	<input type="checkbox"/> Verification Tests
<input type="checkbox"/> Radiation Survey	<input type="checkbox"/> Preventive Maintenance	<input type="checkbox"/> Vendor
<input type="checkbox"/> Other (list) _____		

Fees Due with Application

\$115.00 MDH Processing Fee. Cashier's check/money order attached. Your application will not be processed with a personal or business check. Mail to address below.

Signature

I declare that all the information I have provided is true and complete and that I have read and understand the department's "Tennessee Warning." We are requesting your name, address and phone number so that we may contact you for further information relating to your service provider registration and renewal. You are not required to provide this information. However, without it we will not be able to contact you regarding additional information that may be needed or for renewal of the registration. All information you provide is legally classified as confidential data for individuals and can only be released to Minnesota Department of Health employees as needed to process renewal registration and anyone having a court order to obtain the information.

Applicant Signature _____ Date _____

Before submitting the application, be sure to:

1. Fill out all applicable sections of the application.
2. Include email address.
3. Sign and date the application.
4. Include \$115.00 fee, cashier's check or money order.

Submit to:

Minnesota Department of Health
Radiation Control, X-ray Unit
625 Roberts St N
PO Box 64497
St. Paul, MN 55164-0497
651-201-4545
health.xray@state.mn.us
www.health.state.mn.us

01/21/2026

To obtain this information in a different format, call: 651-201-4545.