**FORMATO DE SOLICITUD DE LICENCIA PARA EQUIPOS DE RAYOS X**

**U OTRAS FUENTES DE RADIACIONES IONIZANTES**

**R. 9031/90**

 Fecha Solicitud \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Solicitud: Primera Vez Renovación Modificación Motivo \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Día Mes Año

Quien HABILITA el Servicio: 1. Profesional Independiente 2. IPS CC O NIT( Para IPS)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­­­­Representante Lega IPS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Profesional Independiente Primer Apellido Segundo Apellido Nombre(s)

Razón Social (Si es IPS)

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Dirección (Ubicación Actual del Equipo) ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cód. del Prestador (Habilitación) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***DATOS DEL EQUIPO:***

| **DATOS** | **COMPLEJIDAD** |
| --- | --- |
| **BAJA** | **MEDIA** | **ALTA** |
| Periapical | RIA | Convencional | Portátil | Panorámico | Densitometría Ósea | Mamografía | Combinados | Scanner | Arco en C | Medicina Nuclear | Radioterapia | Braquiterapia | Acelerador Lineal | PET |
| **Clase de equipo** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Marca** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Modelo** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Serie** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **max. Kv.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **max. mA.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **mev** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Tipo de material**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Actividad** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Estado** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Número** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Tipo de fuente**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Actividad** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Estado** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Número** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Marca** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Modelo** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Serie** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Describa los Procedimientos que realiza: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Especifique los servicios en los que se utilizan los equipos y/o fuentes como apoyo diagnostico y/o complementación terapéutica, relacionados anteriormente:

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Nombre y Firma Representante Legal

Cédula:

|  |
| --- |
| RELACIÓN DE PERSONAL OCUPACIONALMENTE EXPUESTO |
| **Nº** | **Nombre** | **Cédula** | **Profesión** | **Vigencia Carné Radioprotección \*** | **Si es Responsable del Servicio marque con ( X)** | **Servicio** | **Observaciones** |
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\* Se debe anexar copia del carné de radioprotección.

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 Nombre y Firma Representante Legal

 Cédula: