UNITED REPUBLIC OF TANZANIA

Form TAEC 2

Tanzania Atomic Energy Commission
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ATOMIC ENERGY ACT, No. 7 of 2003
[PART I-III SECTION 18 AND 20]

APPLICATION FOR AUTHORIZATION TO POSSESS AND USE MEDICAL DIAGNOSTIC X-RAY EQUIPMENT

NB: To avoid delays in evaluation, respond to all questions

PART I: GENERAL INFORMATION

1. Type of Application: (*tick where appropriate*)	
(a) (☐) New Authorization (☐) Renewal Authorization (☐) Amendment to Authorization	
(b) Financial year: (e.g. *2008/ 2009*)	
2. Name and Address of Organization: (*including head of organization*)	
(a) Legal name of the facility (Institution, firm, hospital, etc.)	
(b) Name of legal Person/ head of organization (Prof. /Dr. / Mr. / Mrs. / Fr. / Rev. / Sr. / other)	
(c) Title of the legal person (e.g. Director, District Medical Officer,etc.	(d) Qualification (e.g. Certificate/ Diploma/ BSc. / Masters in Physics) .....
(e) Permanent mailing address	(f) Telephone numbers Landline: (*Office*) ..... Mobile: (*Office*) ..... (Individual) ..... Fax: (*Office*) ..... Email address: (*Office*) ..... (Individual) .....
(g) Person to be contacted regarding this application (*if different from the above*)	Title: ..... Mobile: ..... Email address: .....

3. Name and information about qualified experts:

(a) Medical practitioner

Give details of Medical practitioner responsible for ensuring over all patient protection and safety in the prescription of and during the performance of Diagnostic x-ray procedures.

Full Name	Tel No.	Address	E-mail	Qualification (e.g. Certificate/ Diploma/ Degree in…) and year of graduation	Training	Experience
.....	.....	.....	.....	.....	.....	.....

(i) To justify and optimize all procedures and actions .....

(ii) in respect of pregnant or potentially pregnant patients .....

(b) Radiation safety officer

Details of a person nominated to be Radiation Safety Officer

Full Name	Tel No.	Address	E-mail	Qualification (e.g. Certificate/ Diploma/ Degree in…) and year of graduation	Training on radiation safety/ protection:		
					Year attended	Institute	Country
.....	.....	.....	.....	.....	.....	.....	.....

(*Attach copies of certificates if not yet submitted to the Commission*)

(c) Details of persons who will administer ionizing radiation to patients (Operators of x-ray equipment)

No	Full Name	Qualification (e.g. Certificate/ Diploma/ Degree in…) and year of graduation	Experience	Duration of operation at the centre (e.g. Since June 2009)	Nature of employment (Part time or full time)	Training on radiation safety/ protection		
						Year attended	Institute	Country
1.	.....	.....	.....	.....	.....	.....	.....	.....
2.	.....	.....	.....	.....	.....	.....	.....	.....
3.	.....	.....	.....	.....	.....	.....	.....	.....
4.	.....	.....	.....	.....	.....	.....	.....	.....
5.	.....	.....	.....	.....	.....	.....	.....	.....

(*Attach copies of certificates if not yet submitted to the Commission*)

* (*Continue on a separate sheet*)

PART II: TECHNICAL DETAILS OF EQUIPMENT

1. List all the devices in possession which produce ionizing radiation when energized (e.g. x-ray equipment, accelerators, cyclotrons, etc.). Give details of each equipment as indicated on the table below:

Device		**Machine 1**	**Machine 2**	**Machine 3**
Manufacturer		.....	.....	.....
Model		.....	.....	.....
Control console/ generator	Tag No.	.....	.....	.....
	Ser. No.	.....	.....	.....
Tube head/ housing	Tag No.	.....	.....	.....
	Ser. No.	.....	.....	.....
Tube insert	Tag No.	.....	.....	.....
	Ser. No.	.....	.....	.....
Maximum operating parameters (Max KV, mAs, mA and timer)		.....	.....	.....
Date of Manufacturer		.....	.....	.....
Date of installation at the centre		.....	.....	.....
Type of installation (Fixed or mobile)		.....	.....	.....
Purpose use (Select among the following: General radiography, Fluoroscopy, CT, Dental, Mamography, Digital subtraction angiography, Others …(*specify*))		.....	.....	.....
Location with the premise (Where the equipment is primarily used e.g. Radiology dept., dental room, ward, theatre room, etc.)		.....	.....	.....
Compliance with International standards e.g. ISO and IEC (Identify the standard and give the classification No.)		.....	.....	.....
Status of the device (Working or defective)		.....	.....	.....
Date it was inspected		.....	.....	.....

Cont… (*If more than three machines*)

Device		**Machine 4**	**Machine 5**	**Machine 6**
Manufacturer		.....	.....	.....
Model		.....	.....	.....
Control console/ generator	Tag No.	.....	.....	.....
	Ser. No.	.....	.....	.....
Tube head/ housing	Tag No.	.....	.....	.....
	Ser. No.	.....	.....	.....
Tube insert	Tag No.	.....	.....	.....
	Ser. No.	.....	.....	.....
Maximum operating parameters (Max KV, mAs, mA and timer)		.....	.....	.....
Date of Manufacturer		.....	.....	.....
Date of installation at the centre		.....	.....	.....
Type of installation (Fixed or mobile)		.....	.....	.....
Purpose use (Select among the following: General radiography, Fluoroscopy, CT, Dental, Mamography, Digital subtraction angiography, Others …(*specify*))		.....	.....	.....
Location with the premise (Where the equipment is primarily used e.g. Radiology dept., dental room, ward, theatre room, etc.)		.....	.....	.....
Compliance with International standards e.g. ISO and IEC (Identify the standard and give the classification No.)		.....	.....	.....
Status of the device (Working or defective)		.....	.....	.....
Date it was inspected		.....	.....	.....

2. Identify who is (or will be) authorized to perform the service and maintenance of the device (Give the organization name and address)		
3. Give the actual location of the premise facility	Name of unit/ department	Building No. (*If applicable*): .....
Region:	Town:	Street/ Area : .....
District:	Room No. (*If applicable*):	Floor: .....

PART III: LAYOUT OF THE INSTALLATION*

1. Is the installation enclosed ☐ or open ☐ ? (*tick where appropriate*)
2. What are the construction materials? .....
3. Does the installation have an interlock system? (*Yes* ☐ / *No* ☐), warning signs? (*Yes* ☐ / *No* ☐) ..... and radiation shields? (*Yes* ☐ / *No* ☐) ..... (*tick/ mention them where appropriate*)
4. Dark room facilities. State the following facilities are available or not (*tick where appropriate*) Manual processor ☐ Automatic processor ☐ Safe light ☐ Timer ☐ Temperature control facility ☐ Different sizes of cassettes ☐
Any other facility not mentioned above/ comments: .....
(*Attach a layout drawing of the installation showing adjacent surroundings. Controlled and supervised areas should be clearly identified in the drawing*)

PART IV: RADIATION PROTECTION AND SAFETY PROGRAMMES AND EMERGENCY PLANS

1. Organizational structure	
(a) Describe your organizational and management control systems, including assignment of responsibilities and clear lines of authority related to radiation safety:	
(i)	Staffing levels: .....
(ii)	Equipment selection: .....
(iii)	Other assignments of the Radiation Safety Officer, authority of the Radiation Safety Officer to stop unsafe operations: .....
(iv)	Personnel training: .....

(v) Maintenance of records:

.....

(vi) How problems affecting safety are identified and corrected:

.....

(vii) Other unsafe/ relevant information:

.....

2. Individual monitoring: (*tick where appropriate*)

(a) Are radiation workers being monitored? (*Yes* ☐ / *No* ☐)	If Yes give the name of institute providing that service .....

Type of personal dosimeters provided to workers?

Thermo luminescent dosimeter (TLD) ☐ Direct reading dosimeter (DRD) ☐ Optically stimulated luminescence (OSL) ☐

Others (*Specify*)	Is the exchange of TLD done within the specified period of time? (*Yes* ☐ / *No* ☐)
Number of personnel being monitored	Any comments to improve the service .....

(b) List the number of protective equipment (e.g. lead apron, gonad shield, etc.) available at the facility.

Lead apron	Qty. (Each)	Gonad shield	Qty. (Each)	Lead gloves	Qty. (Pairs)	Collar shield	Qty. (Each)
	.....		.....		.....		.....

3. Local rules and supervision

(a) Describe your training program to ensure that all appropriate personnel are adequately trained in the correct operating procedures and how their actions may affect safety:

.....

(b) Describe how you would provide workers the information regarding health risks due to occupational exposure:

.....

(c) Describe your policies regarding female workers who become pregnant notification, adoption of working conditions to protect foetus/ embryo and the instructions you will provide to them:

.....

4. Emergency procedures

(a) Provide your emergency procedures to address emergencies such as substantial accidental exposure of an individual or any other emergencies envisaged:

.....

INSTRUCTIONS:

1. *All license fee should be deposited to account No. 4081100065 National Microfinance Bank (NMB) Clock Tower Branch, Arusha OR account No. 201111000096 National Microfinance Bank (NMB) Bank House Branch, Dar es Salaam. Account Name is "Tanzania Atomic Energy Commission".*

   NB. No cash or cheque will be accepted by the commission.

2. *Return the completed and signed application form being attached with bank pay in slip or relevant bank document of the required payment.*
3. *If there is any unfilled item in the application form with specific reasons then give more detailed explanations on a separate sheet of paper.*

PART V: DECLARATION

LEGAL PERSON/ HEAD OF THE CENTER OR REPRESENTATIVE:

I declare that to the best of my knowledge the information provided above are true and correct

Name: ..... Signature : .....

Title: ..... Date: .....

OFFICIAL STAMP OR SEAL

For official use only

(i) Date at which application form was received: ..... .

(ii) Date at which the application was evaluated: ..... .

(iii) Licence/ Registration No.: ..... .

(iv) General remarks and/ or comments: ..... .