



**Registration and Inventory of Medical Equipment**  
**Mobile Lithotripter Equipment**  
**January 2015**

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**Instructions**

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for mobile lithotripter equipment. Please complete all sections of this form and return to the Medical Facilities Planning Branch by **Friday, January 30, 2015**.

1. Complete and sign the form
2. Return the form by one of two methods:
  - a. Email a scanned copy to [DHSR.SMFP.Registration-Inventory@dhhs.nc.gov](mailto:DHSR.SMFP.Registration-Inventory@dhhs.nc.gov)
  - b. Mail the form to Kelli Fisk, Medical Facilities Planning Branch, 2714 Mail Service Center, Raleigh, NC 27699-2714.

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email [DHSR.SMFP.Registration-Inventory@dhhs.nc.gov](mailto:DHSR.SMFP.Registration-Inventory@dhhs.nc.gov).

**Section 1: Contact Information**

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

\_\_\_\_\_ (Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

\_\_\_\_\_ (Street and Number)

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_ (Phone Number)

3. Chief Executive Officer or approved designee who is certifying the information in this registration form:

\_\_\_\_\_ (Name) \_\_\_\_\_ (Title)

\_\_\_\_\_ (Street and Number) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

\_\_\_\_\_ (Phone Number) \_\_\_\_\_ (Email)

4. Information Compiled or Prepared by: \_\_\_\_\_ (Name)

\_\_\_\_\_ (Phone Number) \_\_\_\_\_ (Email)



**Section 2: Equipment and Procedures Information**

Time Period for Report:  10/01/2013 – 9/30/2014     Other time period: \_\_\_\_\_

(Please make additional copies of pages of this form as needed.)

Lithotripter Information (one lithotripter per page)		
Manufacturer		
Model Number		
Serial or I.D. Number		
Date of purchase		
Purchase price		
Certificate of Need Project ID		
Certificate Holder, as listed on Certificate of Need		
<b>NC Hospitals:</b>	Service Site Number _____	Service Site Number _____
Service Site Information: Please include <b>all</b> of the information requested for each location.	Service Site _____	Service Site _____
	Address _____	Address _____
	City, State, Zip _____	City, State, Zip _____
	County _____	County _____
Total number of procedures for report period		
Number of days per year in NC		
<b>NC Non-Hospitals:</b>	Service Site Number _____	Service Site Number _____
Service Site Information: Please include <b>all</b> of the information requested for each location.	Service Site _____	Service Site _____
	Address _____	Address _____
	City, State, Zip _____	City, State, Zip _____
	County _____	County _____
Total number of procedures for report period		
Number of days per year in NC		
<b>Service Sites in Other States:</b>	Service Site Number _____	Service Site Number _____
Service Site Information: Please include <b>all</b> of the information requested for each location.	Service Site _____	Service Site _____
	Address _____	Address _____
	City, State, Zip _____	City, State, Zip _____
	County _____	County _____
Total number of procedures for report period		
Number of days per year in other states		

Name of entity that acquired the equipment (from page 1) \_\_\_\_\_



**Laser Pulverization Equipment**

Site Where Service is Provided	Number of Procedures
Service Site _____ Address _____ _____ City, State, Zip _____ County _____	
Service Site _____ Address _____ _____ City, State, Zip _____ County _____	
Service Site _____ Address _____ _____ City, State, Zip _____ County _____	

**Section 3: Certification and Signature**

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date signed \_\_\_\_\_

Please complete all sections of this form and return to the Medical Facilities Planning Branch by **Friday, January 30, 2015.**

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Name of entity that acquired the equipment (from page 1) \_\_\_\_\_