



Registration and Inventory of Medical Equipment
Mobile Positron Emission Tomography Scanners
January 2015

Instructions

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for mobile positron emission tomography scanners. 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
 - 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.

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.)

Mobile Scanner Information (one scanner 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		
	Service Site Number ____	Service Site Number ____
Service Site Information: Please include all of the information requested for each location.	Service Site _____	Service Site _____
	Address _____	Address _____
	_____	_____
	City, State, Zip _____	City, State, Zip _____
	County _____	County _____
<u>Procedures* – Inpatient</u>	_____	_____
<u>Procedures* – Outpatient</u>	_____	_____
Total # of procedures* for report period	_____	_____
Put a check by the days per week, and write in the hours per day, the scanner is in operation.	___ Sun: ___ hours ___ Mon: ___ hours ___ Tue: ___ hours ___ Wed: ___ hours ___ Thu: ___ hours ___ Fri: ___ hours ___ Sat: ___ hours	___ Sun: ___ hours ___ Mon: ___ hours ___ Tue: ___ hours ___ Wed: ___ hours ___ Thu: ___ hours ___ Fri: ___ hours ___ Sat: ___ hours
Total number of hours in operation by site for report period.		

* PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. PET **procedure** means a single discrete study of one patient involving one or more PET scans.

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



Section 3: Patient Origin Data by Service Site

Please provide the county of residence for each patient who received PET scanner services during the time period of this report. Provide patient origin data separately for each service site. Make additional copies of this page as needed. The total number of patients receiving services should be the same as the total number of procedures reported on page 2 of this form.

Service Site Name: _____

County in which service was provided: _____

Patient County	Number of Patients	Patient County	Number of Patients	Patient County	Number of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other (specify)	
35. Franklin		71. Pender			
36. Gaston		72. Perquimans		Total Number of Patients	

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



Section 4: 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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