RADIOLOGIC TECHNOLOGY SCHOOL AFFILIATED CLINICAL SITE

This form shall be submitted prior to approval of each new affiliated clinical site (ACS). Use this form to notify the Department of any changes regarding affiliated clinical sites.

☐ **New** ☐ **Change** ☐ **Discontinue**

[A] School Information

Name of School	School Identification Number

[B] Facility (Affiliated Clinical Site) Information

Current Facility Registration Number	Expiration Date	
Current Facility Name as Registered with CDPH-RHB		Telephone Number
Current Address (physical location of facility)	City	ZIP Code
Facility Contact Name (**new requests only**)	Email	Telephone Number
Previous Facility Registration Number (if applicable)		
Previous Facility Name as Registered with CDPH-RHB (if applicable)		Telephone Number
Previous Address (if applicable)	City	ZIP Code

[C] Limited Permit Schools, indicate permit category(ies) requested for clinical training:

☐ Chest	☐ Extremities	☐ Torso-skeletal	☐ Skull	☐ Leg-podiatric	☐ Dental laboratory	☐ DEXA

[D] I attest that the information on this form is true and correct.

Name of Designated School Official	Title
Signature of Designated School Official	Date

Mail the completed form to either address below:

Express Mail:
CDPH - Radiologic Health Branch
Certification Unit, MS 7610
1500 Capitol Avenue
Sacramento, CA 95814-5006

Or

Mailing Address:
CDPH - Radiologic Health Branch
Certification Unit, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414