Registration and Inventory of Medical Equipment
Linear Accelerator Equipment
January 2025

Instructions
This is the legally required "Registration and Inventory of Medical Equipment" (G.S. 131E-177) for linear accelerator equipment. Please complete all sections of this form and return to Healthcare Planning by **Friday, January 24, 2025**.

1. **Submit one completed Registration and Inventory form per linear accelerator (LINAC).**
2. Complete and sign the form
3. 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 Andrea Emanuel, Healthcare Planning, 2704 Mail Service Center, Raleigh, NC 27699-2704.

If you have questions, call Andrea Emanuel in Healthcare Planning at (919) 855-3954 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Note: A LINAC operated in a facility licensed under a hospital must be reported on that hospital's license renewal application, and not duplicated on this form.

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

Reporting Period: ☐ 10/01/2023 – 9/30/2024

☐ Other time period: _____

Do not make extra copies of this page if the entity has multiple LINACs at the same site or in the same county. Submit a complete, separate R&I form for each LINAC.

For DHSR Planning Use Only	
Serial or I.D. number	
Model number	
Manufacturer	
Certificate of Need Project ID	
Date of purchase	
Purchase price	
Service Site Information: Please enter **all** the information requested for each location.	Service Site _____ Address _____ _____ City, State, Zip_____ County _____
Configured for stereotactic radiosurgery?	☐ Yes ☐ No
Number of patients* who received radiation oncology treatment on the linear accelerator	
Does service site have Proton Therapy equipment?	☐ Yes ☐ No Total Procedures: _____

* Patients shall be counted once for each course of radiation oncology treatment using the linear accelerator. For example, one patient who receives one course of treatment counts as one, and one patient who receives three courses of treatment counts as three. The number of patients reported here should match the number of patients reported in the Linear Accelerator Treatment Patient Origin chart on page 4 of this form.

Section 2: Equipment and Procedures Information, continued

If the service site has more than one LINAC, provide simulator data on only one R&I form.

(Please make additional copies of pages of this form if this site has more than two simulators.)

	Simulator Number ___**	**Simulator** Number ___**	**Total Units**
For DHSR Planning Use Only			
Serial or I.D. number			
Model number			
Manufacturer			
Certificate of Need Project ID			
Date of purchase			
Purchase price			
Number of unduplicated patients who received treatment simulation			Total Patients

** "... machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient." (GS 131E-176 (24b))

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

Section 3: Linear Accelerator Treatment Data

Enter the number of procedures by CPT Code provided by the LINAC on page 2 (including Cyberknife and similar equipment) during the time period of this report.

CPT Code	Description	Number of Procedures
Simple Treatment Delivery		
77401	Radiation treatment delivery	
77402	Radiation treatment delivery (<=5 MeV)	
77403	Radiation treatment delivery (6-10 MeV)	
77404	Radiation treatment delivery (11-19 MeV)	
77406	Radiation treatment delivery (>=20 MeV)	
Intermediate Treatment Delivery		
77407	Radiation treatment delivery (<=5 MeV)	
77408	Radiation treatment delivery (6-10 MeV)	
77409	Radiation treatment delivery (11-19 MeV)	
77411	Radiation treatment delivery (>=20 MeV)	
Complex Treatment Delivery		
77412	Radiation treatment delivery (<=5 MeV)	
77413	Radiation treatment delivery (6-10 MeV)	
77414	Radiation treatment delivery (11-19 MeV)	
77416	Radiation treatment delivery (>= 20 MeV)	
Other Treatment Delivery Not Included Above		
77418	Intensity modulated radiation treatment (IMRT) delivery and/or CPT codes 77385, 77386 and/or G6015	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multisource Cobalt 60 based (Gamma Knife)	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	
G0339	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery in one session or first fraction	
G0340	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery, fractionated treatment, 2nd-5th fraction	
	Intraoperative radiation therapy (conducted by bringing the anesthetized patient down to the LINAC)	
	Pediatric Patient under anesthesia	
	Neutron and proton radiation therapy	
	Limb salvage irradiation	
	Hemibody irradiation	
	Total body irradiation	
Imaging Procedures Not Included Above		
77417	Additional field check radiographs	
	Total Procedures	

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

Section 4: Linear Accelerator Treatment Patient Origin Data

Please provide the county of residence for unduplicated patients (see note on page 2) during the time period of this report. The total number served should be the same as on page 2. This data is needed to calculate linear accelerator service areas.

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 5: Certification and Signature

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

Signature _____

Print Name _____

Date signed _____

Please complete all sections of this form and return to Healthcare Planning by **Friday, January 24, 2025**.

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