# Registration and Inventory of Medical Equipment
Mobile Lithotriptor Equipment
January 2025

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

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 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.

**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: _____

(Please make additional copies of pages of this form as needed for additional service sites for this lithotriptor.)

| For DHSR Planning Use Only: | |
|---|---|
| | Lithotriptor Information (one lithotriptor 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 | |
| **NC Hospitals**: | **Service Site Number ____** |
| Service Site Information: Please include **all** information requested. | Service Site_____<br>Address _____<br>City, State, Zip _____ County _____ |
| Total number of procedures for reporting period | |
| Number of days per year in NC | |
| **NC Non-Hospitals**: | **Service Site Number ____** |
| Service Site Information: Please include **all** information requested. | Service Site_____<br>Address _____<br>City, State, Zip _____ County _____ |
| Total number of procedures for reporting period | |
| Number of days per year in NC | |
| **Service Sites in Other States**: | **Service Site Number ____** |
| Service Site Information: Please include **all** information requested. | Service Site_____<br>Address _____<br>City, State, Zip _____ County _____ |
| Total number of procedures for reporting period | |
| Number of days per year in other states | |

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

**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 _____

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