Registration and Inventory of Medical Equipment

Mobile Positron Emission Tomography Scanners
January 2025

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 Healthcare Planning by **Friday, January 24, 2025**

1. **Submit one completed Registration and Inventory form per PET scanner**
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.

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 PET scanners. Submit a complete, separate R&I form for each scanner.

(Please make additional copies of this form as needed for additional Service Sites.)

For DHSR Planning Use Only:	
	Mobile Scanner Information (one Service Site 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 Information:	Service Site______________________________ Address ______________________________ City, State, Zip ________________ County ________________
Procedures* – Inpatient Procedures* – Outpatient Total # of procedures* for report period	______________ ______________ ______________
For each day of the week, enter the **number of hours** the scanner is in operation.	_____ Sunday _____ Thursday _____ Monday _____ Friday _____ Tuesday _____ Saturday _____ Wednesday
Total number of hours in operation by site for reporting 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 reporting period. 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 Number: _______

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 ____

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