**Registration and Inventory of Medical Equipment**

Fixed Positron Emission Tomography Scanners

January 2025

**Instructions**

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for fixed 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 fixed PET scanner**
2. Complete and sign the form
3. Return the form by one of two methods:
4. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.
5. 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: Fixed equipment operated in a facility licensed under a hospital should 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)

1. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street and Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (City) (State) (Zip) (Phone Number)

1. 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)

1. 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 at the same site or in the same county. Submit a complete, separate R&I form for each scanner.**

|  |  |
| --- | --- |
| For DHSR Planning Use Only: |  |
|  | **PET Scanner Information** |
| Manufacturer |  |
| Model number |  |
| Serial or I.D. number |  |
| Date of purchase |  |
| Purchase price |  |
| Certificate of Need Project ID |  |
| Service Site Information:  | Service Site\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Total number of procedures\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Inpatient Procedures\* | Outpatient Procedures\* |
|  |  |

**\*** 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.

**Section 3: Patient Origin Data**

Please provide the county of residence for each patient who received PET scanner services during the time period of this report. This data should only reflect the number of patients, not number of scans, and should not include other radiopharmaceutical or supply charge codes. Count each patient only once. The number of patients in this table should match the number of PET procedures reported on page 2 of this report.

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** |  |

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

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