**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:
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.

**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. 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\* – InpatientProcedures\* – OutpatientTotal # 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.

**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** |  |

**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**.

1. Complete and sign the form
2. Return the form by one of two methods:
3. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.
4. Mail the form to Andrea Emanuel in 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.