NOTE: PLEASE ALLOW AT LEAST 30 DAYS FOR ADMINISTRATION BEFORE MAKING ENQUIRIES

SECTION A (To be completed by Dealer)

1. LICENCE HOLDER

|  |  |  |
| --- | --- | --- |
| Name of Dealer as Listed on Licence To Import: | | |
| Contact Person: | | 🕿: |
| Cell: | Fax: | Email: |

**2. PURCHASER**

|  |  |
| --- | --- |
| Name of individual or organization supplied to: | |
| Contact Person: | Cell no: |

**3. PRODUCT INFORMATION AS LISTED ON LICENCE TO IMPORT**

|  |  |  |
| --- | --- | --- |
| Brand: | Year of manufacture: | Import Lic. No.: |
| Model: | | Unit serial No.: |

**3.1** **UNIT DISCRIPTION (Mark applicable with X)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Intra- oral | Pan | Pan / Ceph | CR | DDR | CBCT |

**3.2. PHANTOM (Mark applicable with X. Only if supplied)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Intra - Oral |  | Pan/Ceph |  | CBCT |  |

**3.3.** **TECHNICAL SPECIFICATIONS**

|  |  |  |
| --- | --- | --- |
| Peak tube potential: ......... kV | Maximum mA ……………….……. | Maximum exposure time:…………………s |

# 4. INSPECTION BODY THAT WILL PERFORM ACCEPTANCE TESTS

|  |  |
| --- | --- |
| Inspection Body: | SANAS Ref No.: |

# 5. DECLARATION ( by SUPPLIER)

|  |
| --- |
| **I, ..............................................................................................................................hereby declare that all information supplied is true and correct.**  **Signature: Date:** |

**NB\* Section A & Section B must be submitted simultaneously.**

SECTION B (To be completed by User)

6. PARTICULARS OF APPLICANT

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name (legal person) e.g., a company registered in the RSA,university, government department, hospital, etc.) OR name of partnership/trust etc. | | | | | |
| Section or division of establishment - e.g., university dept, branch or division of company, a hospital (if part of a group), division of a partnership, etc. (if applicable) | | | | | |
| 🕿 | | | Fax no.: | | |
| Email: | | | | | |
| Do you have existing Radiation Control licence(s)? | YES | NO | | If yes, please state one of them | |
| **POSTAL ADDRESS** (To be used for correspondence) | | | | | |
|  | | | | | Postcode: |

**7. INFORMATION OF DEALER**

|  |  |
| --- | --- |
| Name of Dealer that Supplied x-ray unit or components: | |
| Contact Person: | Cell no: |

8. PARTICULARS OF PREMISES (Where unit is to be installed) (Must be completed by end user)

|  |  |  |
| --- | --- | --- |
| Address: - General (i.e., block, floor, room, vehicle reg. no.) | | |
| Section: | Street: | |
| Building: | | |
| Suburb: | Postcode: | User Lic.No:  (If available) |

# 9. RESPONSIBLE PERSON

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please indicate (X)** | Radiographer | Dentist | | Specialist | Dental Therapist | Oral Hygienist | | ID no: |
| Surname: | | | Title: | | Initials: | | HPCSA Reg. | |
| Address: | | | | | | | | |

**10.** **PHANTOM INFORMATION. (Mark applicable with X)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Intra-Oral |  | Pan/Ceph |  | CBCT |  |

# 11. DECLARATION ( by RESPONSIBLE PERSON)

|  |
| --- |
| **I, ..............................................................................................................................hereby declare that all information supplied is true and correct.**  **Signature: Date:** |

**NB\* Section A & Section B must be submitted simultaneously.**