



**Australian Government**  
**Medicare Australia**

# **LSPN**

## **Location specific practice number registration form**

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# Location specific practice number

## Completing your registration form

- A registration form is required for each practice site.
- The form must be signed by the proprietor/s.
- If you need assistance in completing the form please contact Medicare Australia's LSPN information line on 1800 620 589, Monday to Friday, 9am-4.30pm EST.

## Getting extra copies

The form can be photocopied or you can contact Medicare Australia on 1800 620 589.

## Getting your LSPN

- A LSPN will be allocated to your practice site or mobile facility on submission of a properly made registration form to Medicare Australia.
- The LSPN will be activated from the date received at Medicare Australia or a future date if requested.
- Medicare Australia will write to your practice and confirm your registration and advise you of your site's LSPN.
- Registered sites and their allocated LSPN's will be published on Medicare Australia's website at [www.medicareaustralia.gov.au/providers/programs\\_services/medicare/lspn.htm](http://www.medicareaustralia.gov.au/providers/programs_services/medicare/lspn.htm).

## Lodging your form

Send your completed registration form to:

Medicare Australia  
PO Box 1001  
Tuggeranong ACT 2901  
Attn: Eligibility Section (LSPN)

Or fax your completed registration form to Medicare Australia on:

(02) 6124 7229

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## Checklist

- Have you ticked whether you are a practice site or base for mobile facility? (page 5)
- Has the proprietor/s signed the Declaration? (page 10)
- Have you ticked the nature and type of practice? (pages 6 and 7)
- Have you provided all the details required in the equipment list? (pages 11 to 28)
- Have you photocopied and completed extra equipment pages and attached to inside back
- Have you taken a copy of the registration form for your records?

### IMPORTANT

Once this registration form is completed and submitted to Medicare Australia, you must notify Medicare Australia within 28 days of any changes to your business details contained in this registration form.

### Privacy statement

Information provided on this form will be used to allocate a location specific practice number (LSPN) that will enable your practice to participate in the Medicare program. Practice details such as business name, address, allocated LSPN and registration dates will be placed on Medicare Australia's Internet site. Information may be disclosed to the Department of Health and Ageing. All such releases are authorised by law. Information provided in the application form is protected by the secrecy provisions contained in *Section 130 of the Health Insurance Act 1973*. The personal information provided is also protected by the *Privacy Act 1988*.

## Practice site details

Are you registering a: *(please tick a box)*

Practice site?

Base for mobile equipment?

**Note:** Some information contained on this page will be posted on Medicare Australia's LSPN internet site of registered practices.

### PLEASE USE BLOCK LETTERS WHEN COMPLETING FORM

#### Practice site or mobile facility trading name:

*(For example—SMITHTOWN X-RAY CENTRE, NORTHERN HOSPITAL)*

*(If you are registering a hospital department, please state the name of the department. For example Radiology Department or Radiology and Nuclear Medicine Department)*

#### Location of practice site or base for mobile equipment (must be completed)

Building/property name *(if applicable)*:

Suite/Unit/Shop no:  Floor/Level

Lot No/Street no:  Street

*Include whether avenue/road/street*

Suburb:  State  Postcode

Contact telephone no:  Facsimile:

Email address

#### Postal address for all correspondence (if different from above)

Building/property name *(if applicable)*:

Suite/Unit/Shop no:  Floor/Level

Lot No/Street no:  Street name

*Include whether avenue/road/street*

Box no:  Bag no:  Suburb

State  Postcode

## Practice site details

<p><b>Step 1</b></p> <p>Decide which of the following best describes the nature of this practice.</p> <p><b>Group A:</b> A private practice specialising in radiology/nuclear medicine/radiation oncology.</p> <p><b>Group B:</b> A general practice or private specialist medical practice (not as in Group A).</p> <p><b>Group C:</b> Public facility</p>	<p><b>Step 2</b></p> <p>Under that group, decide which best describes the type of practice site and then tick the box next to that number.</p> <p><b>For example:</b> <i>If your practice site is a specialist radiology site, you would look at Group A and then tick the box next to the number under that group that best describes your practice site type.</i></p>
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### Group A—Private specialist radiology/nuclear medicine/radiation oncology

*Please tick the box (one only) that best describes your practice type site.*

- 1 Base for mobile equipment
- 2 Stand-alone practice site (provides any of the above services)
- 3 Part of or co-located with a primary care practice or group
- 4 Part of or co-located with a private specialist medical centre
- 5 Co-located with a public hospital
- 6 Co-located with a private hospital
- 7 Private hospital
- 8 Private hospital co-located with a public hospital
- 9 Other *(please specify):*

**Group B—General Practice or Private Specialist Medical Practice (other than in Group A)**

*Please tick the box (one only) that best describes your practice type site.*

- 1 Base for mobile equipment
- 2 Primary care practice or group
- 3 Sports medicine clinic
- 4 Cardiology practice or group
- 5 Vascular surgery practice or group
- 6 Orthopaedic practice or group
- 7 Obstetric or gynaecological practice or group
- 8 Neurology/neurosurgery practice or group
- 9 Urology practice or group
- 1 Other *(please specify):*

**Group C—Public facility**

*Please tick the box (one only) that best describes your practice type site.*

- 1 Base for mobile equipment
- 2 Public Hospital—Campus  
*(If you are registering more than one public hospital department, please tick the Public Hospital Campus box)*
- 3 Public Hospital—Radiology Department
- 4 Public Hospital—Nuclear Medicine Department
- 5 Public Hospital—Radiation Oncology Department
- 6 Public Hospital—Cardiology Department
- 7 Public Hospital—Vascular Department
- 8 Public Hospital—Orthopaedic Department
- 9 Public Hospital—Obstetrics and Gynaecology Department.
- 10 Public Hospital—Neurology/neurosurgery Department
- 11 Public Hospital—Urology Department
- 12 Other *(please specify):*.....

## Business details

Registered business name:

ABN: 

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### Proprietor details

Please complete the details in the section below that best matches the nature of your proprietorship.

#### Individuals

First name  Surname

#### Partnerships

Full name(s) of all partners. *(If a partner is a company, please state the company name and the ACN.)*  
*(Attach a separate list if required.)*

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#### Company

Name of company of the practice site or mobile facility:

ACN 

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#### Government agency or public body

Name of government agency (proprietor) of the practice site or mobile facility:

ACN 

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## Business and proprietor details

**Authorised representative** (must be completed for partnerships, companies, Government agencies and public authorities)

Title  First name  Surname

Position title

Contact telephone number  Facsimile

Email address

**Proprietor's address** (for proprietors of mobile bases only—must be completed)

Building/property name *(if applicable)*:

Suite/Unit/Shop no:  Floor/Level

Lot no/Street no:  Street name

Suburb  State  Postcode   
*Include whether avenue/road/street*

## Proprietor declaration

I/We hereby apply for a location specific practice number (LSPN) for the practice site or base for mobile equipment described in this application.

I/We understand that Medicare Australia may:

- request further information regarding details on this application form from the proprietor or authorised representative nominated on this form; and
- provide information (which may include identifying information) relating to this application to the Department of Health and Ageing for statistical, research and policy development purposes.

I/We certify that the statements made in this application and in the accompanying documents are, to the best of my knowledge, true and correct in every detail.

I/We agree to inform Medicare Australia without delay, at the address shown at the beginning of this registration form, any changes to business details.

I/We have nominated an authorised representative?  Yes  No

**Note**  
**For partnerships, companies, government agencies and public bodies, an authorised representative must be nominated.**

**I/We DECLARE that I/We have the appropriate authority to sign this registration form.**

Signature of proprietor(s).

(1)			
	<i>Signature</i>	<i>Name</i>	<i>Position held</i>
(2)			
	<i>Signature</i>	<i>Name</i>	<i>Position held</i>
(3)			
	<i>Signature</i>	<i>Name</i>	<i>Position held</i>

Dated this  Day of  Year

COMPANY SEAL

## Equipment details

### Step 1:

Tick the appropriate boxes for each type of equipment located at this practice site or base for mobile equipment

### Step 2:

Complete the relevant part with details of the equipment.

- Ultrasound *(page 12-14)*
- Computed Tomography *(page 15)*
- Nuclear Medicine Imaging *(page 16—17)*  
(that is PET scanner, Gamma Camera)
- Angiography *(page 18)*
- Diagnostic Radiology *(page 19—20)*  
(that is X-ray, Mammography, Fluoroscopy, and Orthopantamography equipment)
- Magnetic Resonance Imaging (MRI) *(page 21)*
- Radiation Oncology *(page 22—28)*  
(that is Linear accelerators, Cobalt units, Simulators/Localisers, CT Interfacing Planning)

#### **Before completing your equipment details, please:**

- check the number of units you will be registering; if there is insufficient space to record all your units please photocopy the relevant page of equipment for which you are providing details. For example, if you have more than three ultrasound units, please photocopy the required number of extra ultrasound pages you need;
- staple the additional equipment details to the back of the registration form; and
- include your practice name on the additional equipment pages in case they become detached from the application and number the pages.

# Ultrasound

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## Ultrasound unit

Equipment type  Doppler  Non-Doppler

With echocardiography?  Yes  No

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Ultrasound unit

Equipment type  Doppler  Non-Doppler

With echocardiography?  Yes  No

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Ultrasound unit

Equipment type  Doppler  Non-Doppler

With echocardiography?  Yes  No

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Ultrasound

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**Ultrasound unit**Equipment type  Doppler  Non-DopplerWith echocardiography?  Yes  NoSerial no: Model type/no: Manufacturer (*Company*): 

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No 

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

 ABN 

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**Ultrasound unit**Equipment type  Doppler  Non-DopplerWith echocardiography?  Yes  NoSerial no: Model type/no: Manufacturer (*Company*): 

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No 

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

 ABN 

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**Ultrasound unit**Equipment type  Doppler  Non-DopplerWith echocardiography?  Yes  NoSerial no: Model type/no: Manufacturer (*Company*): 

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No 

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

 ABN



# Computed Tomography

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## Gantry component *(details of gantry only required)*

Serial no:

Model type/no:

Manufacturer *(Company)*:

Date manufactured:

*(for equipment that has previously been used outside Australia)*

**OR**

Date first installed in Australia:

*(for new equipment or equipment previously used in Australia)*

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Gantry component *(details of gantry only required)*

Serial no:

Model type/no:

Manufacturer *(Company)*:

Date manufactured:

*(for equipment that has previously been used outside Australia)*

**OR**

Date first installed in Australia:

*(for new equipment or equipment previously used in Australia)*

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Gantry component *(details of gantry only required)*

Serial no:

Model type/no:

Manufacturer *(Company)*:

Date manufactured:

*(for equipment that has previously been used outside Australia)*

**OR**

Date first installed in Australia:

*(for new equipment or equipment previously used in Australia)*

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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# Nuclear Medicine Imaging

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## PET scanner

Serial number of the Ring

Model type/number:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## PET scanner

Serial number of the Ring

Model type/number:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## PET scanner

Serial number of the Ring

Model type/number:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## PET scanner

Serial number of the Ring

Model type/number:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Nuclear Medicine Imaging

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## Gamma camera

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Gamma camera

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Gamma camera

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Gamma camera

Serial no:

Model type/no:

Manufacturer (*Company*):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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# Angiography

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## Angiography

Serial number of the generator:

Model type/no:

Manufacturer (Company):

Date manufactured:  /  /  (for equipment that has previously been used outside Australia)

**OR**

Date first installed in Australia:  /  /  (for new equipment or equipment previously used in Australia)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Angiography

Serial number of the generator:

Model type/no:

Manufacturer (Company):

Date manufactured:  /  /  (for equipment that has previously been used outside Australia)

**OR**

Date first installed in Australia:  /  /  (for new equipment or equipment previously used in Australia)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

---

## Angiography

Serial number of the generator:

Model type/no:

Manufacturer (Company):

Date manufactured:  /  /  (for equipment that has previously been used outside Australia)

**OR**

Date first installed in Australia:  /  /  (for new equipment or equipment previously used in Australia)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Diagnostic radiology

- X-ray                       Mammography  
 Fluoroscopy               Orthopantamography

*Please tick the corresponding box of the diagnostic radiology unit you are registering.*

Serial no:

Model type/no:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

- X-ray                       Mammography  
 Fluoroscopy               Orthopantamography

*Please tick the corresponding box of the diagnostic radiology unit you are registering.*

Serial no:

Model type/no:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

- X-ray                       Mammography  
 Fluoroscopy               Orthopantamography

*Please tick the corresponding box of the diagnostic radiology unit you are registering.*

Serial no:

Model type/no:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Diagnostic radiology

- X-ray                       Mammography  
 Fluoroscopy               Orthopantamography

*Please tick the corresponding box of the diagnostic radiology unit you are registering.*

Serial no:

Model type/no:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

- X-ray                       Mammography  
 Fluoroscopy               Orthopantamography

*Please tick the corresponding box of the diagnostic radiology unit you are registering.*

Serial no:

Model type/no:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

- X-ray                       Mammography  
 Fluoroscopy               Orthopantamography

*Please tick the corresponding box of the diagnostic radiology unit you are registering.*

Serial no:

Model type/no:

Manufacturer (Company):

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Magnetic Resonance Imaging (MRI)

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## Magnetic Resonance Imaging (MRI)—*Medicare Eligible*

Magnetic strength (*tesla units*):

Serial number of magnet:

Model:

Manufacturer (*Company*):

Date commissioned:

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Magnetic Resonance Imaging (MRI)—*Non-Medicare Eligible (optional to complete)*

Magnetic strength (*tesla units*):

Serial number of magnet:

Model:

Manufacturer (*Company*):

Date commissioned:

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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# Radiation Oncology

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## Linear accelerator

Dual modality

Single photon linear

HPG no: *(if applicable)*

Serial no:

Model: type/no:

Manufacturer *(Company)*:

Does this linear accelerator have any or all of the following additional features? *(Please tick)*

**MLC**  Yes  No

**EPI**  Yes  No

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Linear accelerator

Dual modality

Single photon linear

HPG no: *(if applicable)*

Serial no:

Model: type/no:

Manufacturer *(Company)*:

Does this linear accelerator have any or all of the following additional features? *(Please tick)*

**MLC**  Yes  No

**EPI**  Yes  No

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Radiation Oncology

---

## Linear accelerator

Dual modality  Single photon linear

HPG no: *(if applicable)*

Serial no:

Model: type/no:

Manufacturer *(Company)*:

Does this linear accelerator have any or all of the following additional features? *(Please tick)*

**MLC**  Yes  No

**EPI**  Yes  No

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Linear accelerator

Dual modality  Single photon linear

HPG no: *(if applicable)*

Serial no:

Model: type/no:

Manufacturer *(Company)*:

Does this linear accelerator have any or all of the following additional features? *(Please tick)*

**MLC**  Yes  No

**EPI**  Yes  No

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Yes  No

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# Radiation Oncology

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Dual modality                       Single photon linear

HPG no: *(if applicable)*

Serial no:

Model: type/no:

Manufacturer *(Company)*:

Does this linear accelerator have any or all of the following additional features? *(Please tick)*

**MLC**  Yes  No

**EPI**  Yes  No

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Dual modality                       Single photon linear

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# Radiation Oncology

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## Simulator/Localiser unit

With CT

Without CT

HPG no: *(if applicable)*

Serial no:

Model/type no:

Manufacturer *(Company)*:

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Simulator/Localiser unit

With CT

Without CT

HPG no: *(if applicable)*

Serial no:

Model/type no:

Manufacturer *(Company)*:

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Yes  No

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ABN

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## Simulator/Localiser unit

With CT

Without CT

HPG no: *(if applicable)*

Serial no:

Model/type no:

Manufacturer *(Company)*:

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Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

# Radiation Oncology

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## CT interface planning computers

HPG no: *(if applicable)*

Serial no:

Model/type no:

Manufacturer *(Company)*:

No of workstations:

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## CT interface planning computers

HPG no: *(if applicable)*

Serial no:

Model/type no:

Manufacturer *(Company)*:

No of workstations:

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## CT interface planning computers

HPG no: *(if applicable)*

Serial no:

Model/type no:

Manufacturer *(Company)*:

No of workstations:

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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# Radiation Oncology

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## Brachytherapy

HPG no: *(if applicable)*

Auto-after loading

Manually loaded

Serial no:

Model/type no:

Manufacturer *(Company)*:

No of workstations:

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Brachytherapy

HPG no: *(if applicable)*

Auto-after loading

Manually loaded

Serial no:

Model/type no:

Manufacturer *(Company)*:

No of workstations:

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

If yes, please provide the person's name and/or, if applicable, the registered business name and ABN:

ABN

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## Brachytherapy

HPG no: *(if applicable)*

Auto-after loading

Manually loaded

Serial no:

Model/type no:

Manufacturer *(Company)*:

No of workstations:

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

Yes  No

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ABN

**PLEASE ATTACH EXTRA EQUIPMENT DETAILS HERE**

**Important**

Include your practice name on additional equipment pages  
and number pages, for example 1 of 3