DATE: _____

ATTENTION: **REGISTRATION DEPARTMENT** (fax) 615-532-0385

FACILITY:

REGISTRATION #: _____

TOTAL X-RAY UNITS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

REQUEST: DELETION OF X-RAY UNIT

DATE OF REMOVAL: _____

REMOVED BY:
CONTACT (NAME):
PHONE:

CONTROL #:
MAKE/MODEL:
TUBE SN:
CONSOLE SN:
ALT SN:

Please remove the above X-ray unit from my registration.

_____

DENTIST/OWNER DATE