



X-Ray Machine Inspection Report

FACILITY ID NO:

PAGE

OF

FACILITY	FACILITY NAME			SPECIFY PRACTICE TYPE	HOSPITAL	
	ADDRESS				MEDICAL	
	CITY	ST	ZIP		DENTAL	
	PHONE	EMAIL			VETERINARY	
INSPECTOR	NAME				PODIATRIC	
	SIGNATURE				CHIROPRACTIC	
	DATE	PHONE			NON-MEDICAL	

TOTAL NO. X-RAY TUBES AT THIS LOCATION	NO. TUBES INSPECTED	NO. OF SERIOUS VIOLATIONS DISCOVERED	NO. OF NON-SERIOUS VIOLATIONS
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[illegible]