Radiation Control, X-ray Unit
625 North Robert Street
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4545
www.health.state.mn.us/xray

SERVICE PROVIDER
Change in Information Form

A. General Information (Please select all changes)

- ☐ Name Change
- ☐ Address Change
- ☐ Employer Change
- ☐ Other (specify) _____
- ☐ Phone Number Change
- ☐ Email Address Change
- ☐ Manufacturer Change

B. OLD Information

Service Provider Name:	Service Provider Number:
Home Address:	Phone Number:
	Email Address:
Employer Name:	
Employer Address:	

C. NEW Information

Service Provider Name:	Service Provider Number:
Home Address:	Phone Number:
	Email Address:
Employer Name:	Additional Manufacturers:
Employer Address:	

D. Signature

I understand the applicable requirements of Minnesota Rules, Chapter 4732, Ionizing Radiation. The information provided in this form is true and complete. I will notify the Minnesota Department of Health, Radiation Control Unit, immediately of any additional changes.

Service Provider Signature _____ Date _____

MAIL TO: ADDRESS ABOVE
FAX TO: 651-201-4606