

Shielding Proposal

INSTRUCTIONS: Please fill out *all fields* of the form below, sign and fax to Bio-Med Associates at: 908-788-6757

I am pleased to present you with this proposal for Radiological/Health Physics services, regarding Shielding Requirements and Radiation Protection Survey of your equipment for the facility named below.

The calculations for the shielding report will be made in accordance with the recommendations of the National Council on Radiation Protection, and in accord with state regulations. Approximately three man-hours will be needed to complete the shielding requirements for each room. Any changes regarding the location of equipment, barriers, or the occupancy of all adjacent areas, will necessitate recalculation of the barrier specifications.

The fee for shielding physics service is \$200.00 per hour. An invoice along with color coded sketch of the barrier specifications will be presented following service, payment must be received within 30 days from receipt of invoice. Upon receipt of payment, the final processed report will be mailed. A small surcharge is required for credit card payments. Payments made past the due date are subject to 1 1/2% per month finance charge. If collection becomes necessary the facility and/or signer named below will be responsible for the principal amount due, all collection costs, interest, and all attorney fees.

After completion of the room and installation of the equipment Bio-Med Associates will perform a Radiation Protection Survey and performance evaluation on your equipment in full compliance with all State and FDA regulations. This will assure that the equipment complies with all radiation safety regulations, and equipment performance specifications and regulations. Measurements of radiation levels will be made inside and outside the room (if necessary), as well as measurements of all regulated machine parameters including kVp, mAs, focal spot size, radiation output, collimator alignment, phototimer reproducibility, etc.

General radiographic equipment can usually be completed in four hours; multiple tubes will require additional time. This estimate includes the medical physics requirement specified for each state. To establish a new QA program an additional two to four hours may be required, depending on the level of training required by your staff. Please review the attached QA equipment you will need to implement the program. Please contact us if you have questions. A copy of the most recent radiation protections survey must be available for review. Additional visits may be necessary if the equipment is not available during the physicist's visit. A QA Manual with written procedures and sample forms will be provided with acceptance of this proposal. Patient dosimetry measurements and calculations are optionally available upon request.

The fee for this service is \$200.00 per hour. There is a three hour minimum for site visits. Routine service is 9 a.m. to 5 p.m., however, other times are available upon request. Payment is required upon completion of service. Upon receipt of payment your official report will be sent to you within one business day. A small surcharge is required for credit card payments. Payments made thirty days past the due date are subject to 1 1/2% per month finance charge. If collection becomes necessary the facility and/or signer named below will be responsible for the principal amount due, all collection costs, interest, and all attorney fees.

You will be advised of the date and time of each of the physicist's visits. If this needs to be changed, please provide two weeks' notice. Cancellations are subject to a 3 hour fee. In addition, the facility named below agrees not to solicit or hire any employee or individual under contract with Bio-Med Associates, Inc., at any time for any service without written permission from Bio-Med Associates, Inc.

Please sign below and fax or mail at your earliest convenience to schedule service. This proposal is valid for 60 days. Thank you for the opportunity of presenting this proposal. If I can be of further assistance, please feel free to contact me.

Sincerely,

BIO-MED ASSOCIATES, INC.
Jack J. Merkin, M.S.
President

Accepted by (please sign here): _____ **Date:** _____

Print Name: _____ **Title:** _____

Facility Name: _____ **Owner/CEO's Name:** _____

Address: _____

Phone #: _____ **P.O. # (if applicable):** _____