



Registration and Inventory of Medical Equipment

Cardiac Catheterization Equipment

January 2026

Instructions

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for cardiac catheterization equipment. Please complete all sections of this form and return to Healthcare Planning by **Friday, January 23, 2026**.

1. **Submit one completed Registration and Inventory form per unit of cardiac catheterization equipment. Do not combine multiple forms into a single pdf or Word document/file.**
2. Complete and sign the form. **Do not password-protect the document or lock the file for editing.**
3. Return the form by one of two methods:
 - a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.
 - b. Mail the form to Andrea Emanuel, Healthcare Planning, 2704 Mail Service Center, Raleigh, NC 27699-2704.

If you have questions, call Andrea Emanuel in Healthcare Planning at (919) 855-3954 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Note: Fixed equipment operated in a facility licensed under a hospital should be reported on that hospital’s license renewal application, and not duplicated on this form.

Section 1: Contact Information

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

(Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

(Street and Number)

(City) (State) (Zip) (_____) (Phone Number)

3. Chief Executive Officer or approved designee who is certifying the information in this form:

(Name) (Title)

(Street and Number) (City) (State) (Zip)

(_____) _____
(Phone Number) (Email)

4. Information compiled or prepared by: _____
(Name)

(_____) _____
(Phone Number) (Email)



Section 2: Equipment and Procedures Information

Reporting Period: 10/01/2024 – 9/30/2025 Other time period: _____

(Make copies of this page to enter additional service sites.)

For DHSR Planning Use Only		
	Cardiac Catheterization Site No: _____	
Fixed or mobile equipment?	(check one) Fixed: <input type="checkbox"/> Mobile: <input type="checkbox"/>	
Manufacturer		
Model number		
Serial or I.D. number		
Certificate of Need Project ID		
Certificate holder, as listed on Certificate of Need		
Service Site _____		
Address _____		
City, State, Zip _____		County _____
Cardiac Catheterization, as defined in NCGS 131E-176(2g)	Diagnostic Cardiac Catheterization **	Interventional Cardiac Catheterization***
Number of units of fixed equipment		
Number of procedures* performed in fixed units on patients age 14 and younger		
Number of procedures* performed in fixed units on patients age 15 and older		
Number of procedures* performed in mobile units		
Dedicated Electrophysiology (EP) Equipment		
Number of Units of Fixed Equipment		
Number of Procedures on Dedicated EP Equipment		

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit. For example, if a patient has both a diagnostic and an interventional procedure in one visit, count only the interventional procedure.

** “a cardiac catheterization procedure performed for the purpose of detecting and identifying defects or diseases in the coronary arteries or veins of the heart, or abnormalities in the heart structure, but not the pulmonary artery.” 10A NCAC 14C .1601(9)

*** “a cardiac catheterization procedure performed for the purpose of treating or resolving anatomical or physiological conditions which have been determined to exist in the heart or coronary arteries or veins of the heart, but not the pulmonary artery.” 10A NCAC 14C .1601(16)

Name of entity that acquired the equipment (from page 1) _____



	Cardiac Catheterization Equipment No: ____
For each day of the week, enter the number of hours the equipment is in operation.	____ Sunday ____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____ Saturday
Total number of hours in operation during reporting period.	
Number of 8-hour days per week the mobile unit is onsite: _____ 8-hour days per week. (Examples: Monday through Friday for 8-hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)	

Section 3: Certification and Signature

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all preceding pages of this form.

Do not password protect the document or lock it for editing.

Signature _____

Print Name _____

Date signed _____

Please complete all sections of this form and return to Healthcare Planning by **Friday, January 23, 2026.**

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