



**Registration and Inventory of Medical Equipment**  
**Mobile Lithotripter Equipment**  
**January 2026**

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**Instructions**

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for mobile lithotripter 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 lithotripter. 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](mailto: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](mailto:DHSR.SMFP.Registration-Inventory@dhhs.nc.gov).

**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 registration 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: \_\_\_\_\_

(Please make additional copies of pages of this form as needed for additional service sites for this lithotripter.)

For DHSR Planning Use Only:	
	<b>Lithotripter Information (one lithotripter per page)</b>
Manufacturer	
Model number	
Serial or I.D. number	
Date of purchase	
Purchase price	
Certificate of Need Project ID	
Certificate holder, as listed on Certificate of Need	
<b>NC Hospitals:</b>	<b>Service Site Number _____</b>
Service Site Information: Please include <b>all</b> information requested.	Service Site _____ Address _____ City, State, Zip _____ County _____
Total number of procedures for reporting period	
Number of days per year in NC	
<b>NC Non-Hospitals:</b>	<b>Service Site Number _____</b>
Service Site Information: Please include <b>all</b> information requested.	Service Site _____ Address _____ City, State, Zip _____ County _____
Total number of procedures for reporting period	
Number of days per year in NC	
<b>Service Sites in Other States:</b>	<b>Service Site Number _____</b>
Service Site Information: Please include <b>all</b> information requested.	Service Site _____ Address _____ City, State, Zip _____ County _____
Total number of procedures for reporting period	
Number of days per year in other states	

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



**Section 3: Certification and Signature**

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all 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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Name of entity that acquired the equipment (from page 1) \_\_\_\_\_