Registration and Inventory of Medical Equipment
Fixed Magnetic Resonance Imaging Scanners
January 2026

Instructions
This is the legally required "Registration and Inventory of Medical Equipment" (G.S. 131E-177) for fixed magnetic resonance imaging (MRI) scanners. 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 MRI scanner. 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 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: _____

Do not make extra copies of this page if the entity has multiple MRIs in the same county. Submit a complete, separate R&I form for each scanner.

DHSR Planning Use Only	
Manufacturer / Tesla	/
Model Number	
Open or closed (including open bore) scanner	☐ Open ☐ Closed
Serial or I.D. number	
Date of acquisition	
Purchase price (if purchased)	
Certificate of Need Project ID (or Legacy)	☐ Legacy
Certificate holder, as listed on Certificate of Need	
If this equipment was originally a mobile scanner, check the appropriate box below if it is now parked or installed. **DO NOT COMPLETE THIS ITEM IF THE SCANNER WAS INITIALLY APPROVED AS A FIXED SCANNER.**	
• permanently parked ("wheels off" or on) or • installed in a building	☐ Parked ☐ Installed
Service Site Information: Please include **all** the information requested.	Service Site_____ Address _____ City: _____ Zip_____ County _____
Inpatient Procedures*: - with Contrast or Sedation - without Contrast or Sedation Outpatient Procedures*: - with Contrast or Sedation - without Contrast or Sedation **Total Number of Procedures**	Inpatient: with: _____ w/out: _____ Total: _____ Outpatient: with: _____ w/out: _____ Total: _____ **Total**: _____
For each day of the week, enter the **number of hours** the scanner is in operation.	___ Sunday ___ Thursday ___ Monday ___ Friday ___ Tuesday ___ Saturday ___ Wednesday
Total number of hours in operation for reporting period	

*An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. **The total number of procedures should be equal to or greater than the total number of patients reported on the MRI Patient Origin Table on page 3 of this form.**

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

Section 3: Patient Origin Data

Please provide the county of residence for each patient who received MRI services during the time period of this report. The total number of patients receiving services should be equal to or less than the total number of procedures reported on page 2 of this form.

County in which service was provided: _____

Patient County	Number of Patients	Patient County	Number of Patients	Patient County	Number of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other states	
35. Franklin		71. Pender			
36. Gaston		72. Perquimans		**Total Number of Patients**	

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

Section 4: 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 _____

Note: Healthcare Planning and Certificate of Need may request CPT codes for MRI procedures if further clarification is needed.

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

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