



**X-RAY TUBE
 Installation Report**

Date: _____

Customer: _____

Checked By: _____

A. X-ray Tube

Type No.: _____ Serial No.: _____
 Date Received: _____ Date Installed: _____

B. Information of Equipment

What is x-ray tube used for? Please check:

Fluoroscopy	Industrial/Therapy	Radiography	Tomography
Spot Film	Angio/Cine	Mammography	CT
Dental	Portable	Other _____	

X-Ray Generator: Manufacturer _____
 Model # _____
 Maximum KV _____
 Maximum MA _____

Rotor Control: Manufacturer _____
 Model # _____

C. Inspection of Housing

Please note any defects upon receipt:

Oil Seals _____
 Radiation Port _____
 Receptacles _____
 Stator _____
 Thermal Switch/Heat Sensor _____
 Heat Exchanger/Cooler _____

D. Inspection of Insert Tube

Please note any defects upon receipt:

Glass Envelope _____
 Vacuum Condition _____
 Target Surface _____
 Anode/Cathode Surface _____
 Filaments _____
 Rotation of Anode _____

E. List any difficulties experienced during installation and calibration.

