



## PROCEDURES FOR APPLYING FOR INITIAL LICENSURE OF SERVICE LINES FOR PHYSICIAN OFFICES

1. Beginning December 1, 2025, and thereafter you must submit an MRI and/or PET licensure application to the Health Facilities Commission followed by the designated fee.

Licensing fee schedule is listed at the end of the application.

2. Please complete the entire application responding to each applicable field. All applications must be signed by an authorized representative. Incomplete or unsigned applications will be returned which may delay the processing of the application.
3. All applications will need to be emailed to [hfc.service@tn.gov](mailto:hfc.service@tn.gov) . An email will be sent to the applicant within two (2) business days of receipt verifying that the application was received.
4. Please review HFC's Medical Equipment Registry to ensure information submitted on the licensure application is consistent with previously submitted data.
5. Upon receipt of the application, HFC staff will review the application for completeness. Once determined to be complete, a service license number will be assigned, and an invoice will be sent to the listed billing contact. The requested license fee will need to be submitted to Health Facilities Commission, following the invoice instructions, by listed due date on the invoice.
6. Once the license fees have been received, a provisional approval letter will be sent to the listed CEO/Administrator. The application will then be presented to the Commission at the next regularly scheduled Commission meeting for ratification.
  - If the Commission ratifies the application, the license certificate will then be created and mailed to the licensee. You should receive the physical license in ten (10) to fourteen (14) days.
  - If the Commission does not ratify the initial approval of your application, a letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

*All applicable laws, rules, policies, and guidelines are available for viewing at <https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html>. Please check this website periodically for updates.*

**Please note the licensure application does not take the place of the HFC Medical Equipment Registry. Medical Equipment Yearly submissions are still required.**



**State of Tennessee**  
**Health Facilities Commission**

502 Deaderick Street, Andrew Jackson Building, 9<sup>th</sup> Floor, Nashville, TN 37243  
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

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**INITIAL APPLICATION FOR LICENSE OF SERVICES  
FOR PHYSICIAN OFFICES**

**1. NAME AND PHYSICAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE**

Tennessee Medical Imaging, P.C., dba RAYUS Radiology

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**Name**

537 Stonecrest Parkway Ste 102

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**Address**

Smyrna

TN

37167

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**City**

**State**

**ZIP**

**2. CEO/ADMINISTRATOR OF PROVIDER**

James Busch, M.D.

Owner, Medical Director

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**Name**

**Title**

JMBusch@drcriology.com

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**Email Address**

Tennessee Medical Imaging, P.C., dba RAYUS Radiology

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**Company Name**

537 Stonecrest Parkway Ste 102

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**Address**

Smyrna

TN

37167

---

**City**

**State**

**ZIP**

615-890-8999

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**Phone Number**

**3. BILLING INFORMATION FOR FACILITY**

Jennifer McGee		Administrative Operations Manager	
<b>Name</b>		<b>Title</b>	
Jennifer.McGee@RAYUSRadiology.com			
<b>Email Address</b>			
Tennessee Medical Imaging, P.C. dba RAYUS Radiology			
<b>Company Name</b>			
537 Stonecrest Pkwy, Ste 102			
<b>Address</b>			
Smyrna		TN	37167
<b>City</b>		<b>State</b>	<b>ZIP</b>
615-890-8999			
<b>Phone Number</b>			

**4. OWNERSHIP OF FACILITY**

James Busch, M.D.			
<b>Name of Owner</b>			
537 Stonecrest Parkway Ste 102			
<b>Address</b>			
Smyrna		TN	37167
<b>City</b>		<b>State</b>	<b>ZIP</b>
615-890-8999			
<b>Phone Number</b>			

**Legal Entity:**

<input checked="" type="checkbox"/> Individual	<input type="checkbox"/> Limited Liability	<input type="checkbox"/> Corporation (For Profit)
<input type="checkbox"/> Corporation (Not for Profit)	<input type="checkbox"/> Government	<input type="checkbox"/> Limited Partnership
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Professional Limited Liability Company	
<input type="checkbox"/> Other	_____	

List name(s) and addresses of individual owners, partners, directors of the corporation, or head of the government entity. (If more than two (2), please use ATTACHMENT – B.)

James Busch, M.D.

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(1) Name

537 Stonecrest Parkway Ste 102

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Address

Smyrna

TN

37167

---

City

State

ZIP

---

(2) Name

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Address

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City

State

ZIP

If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility?  Yes  No  Not Applicable

If no, why:

Is this facility chain affiliated?  Yes  No

If a corporation, is there a holding company?  Yes  No

If yes, please complete the following information of the holding company.

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Name of Owner

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Address

---

City

State

ZIP

---

Phone Number

Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?  Yes  No

If yes, list their names and addresses of all facilities.:

Primelmaging - Battlefield 4632 Battlefield Parkway, Ringgold, GA 30736 Primelmaging - Chattanooga Outpatient Center 1301 McCallie Ave., Chattanooga, TN 37404 Primelmaging 1604 Gunbarrel Road, Chattanooga, TN 37421
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Is there a contract with a management firm to operate this facility?  Yes  No

If yes, please specify the dates of the contract and complete the firm's information.

Start Date: June 22, 2017 End Date: current

CDI Tennessee, LLC

Name of Firm

5775 Wayzata Blvd Ste 400 - Legal

Address

Minneapolis

MN

55416

City

State

ZIP

Email to: Legal@cdirad.com

Phone Number

## 5. LEGAL

If any of the items within this section (LEGAL), please identify, explain, and provide documentation of the item(s) noted if response is "yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states listed, or the management firm listed been subjected to any of the following within the past five (5) years?

### Licensure

- Denied a License  Yes  No
- Had a license suspended or revoked by any state licensure agency?  Yes  No
- Been subject to a final order or judgement in a state licensure action?  Yes  No

### Convictions

- If convicted of a criminal offense related to that person's involvement in any program under any state or federal health care program – including Medicare, Medicaid, and TriCare?  Yes  No

**Exclusion**

➤ Excluded from participation in federal health care programs – Medicare, Medicaid, CHIP, or TriCare – in the past?  Yes  No

(Excluded is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare.)  Yes  No

**Termination/Suspension**

➤ Suspended or terminated from participation in Medicare or Medicaid/TennCare programs?  Yes  No

**Fraud and Abuse**

➤ Paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services?  Yes  No

**Corporate Integrity Agreement**

➤ Is presently an entity covered by and subject the terms of a corporate integrity agreement? (If yes, please provide a copy of CIA.)  Yes  No

**Bankruptcy**

➤ Filed bankruptcy under any provision of the United States Bankruptcy Code:  Yes  No

**Civil Monetary Penalty (CMP)**

➤ Paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000 as a result of an enforcement action during a survey?  Yes  No

**6. On the following items, check all appropriate services to be licensed.**

**ESTABLISHING MRI UNIT/SERVICE:** (If more than one unit, use ATTACHMENT – A.)

Physical Address of Service: 537 Stonecrest Pkwy, Ste 102

Name Brand of Unit Hitachi (used) Oasis

Tesla 1.2T

Type (i.e. Close, Short Bore, etc.) Open

Unit's Serial Number M115

Will the MRI Unit be Accredited?:  Yes  No

If MRI Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? ACR  
(Attach certificate or proof of accreditation.)

If no, why:

The MRI unit will be registered with the Health Facilities Commission.  Yes  No

**ESTABLISHING PET UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: \_\_\_\_\_

Name Brand of Unit \_\_\_\_\_

Type (i.e. PET Only, PET/CT, PET/MRI) \_\_\_\_\_

Unit's Serial Number \_\_\_\_\_

Will the PET Unit be Accredited?:  Yes  No

If PET Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? \_\_\_\_\_  
(Attach certificate or proof of accreditation.)

If no, why:

The PET unit will be registered with the Health Facilities Commission.  Yes  No

Pursuant to Tennessee Rule of Civil Procedure 72, I hereby declare under perjury that the information provided in this application is true and correct. Signee for this application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or services for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated §68-11-201 and Rules 0720-.14, 0720-36, and 0720-47 adopted by the Commission effective December 1, 2025. Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA §71-6-103 to report incidents of abuse or neglect.



December 23, 2025

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Signature

Date

Per Normark, Secretary

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Printed Name

## Non-Refundable Licensing Fees for Listed Licensed Services

An invoice will be sent to the contact for Billing for total payment of fees.

### **MRI:**

Hospital: \$500 per MRI unit  
Outpatient Diagnostic Center: Included with ODC License  
Physician Office: \$500 per MRI unit

### **PET:**

Hospital: \$500 per MRI unit  
Outpatient Diagnostic Center: Included with ODC License  
Physician Office: \$500 per MRI unit

*(as of December 1, 2025)*

AMERICAN COLLEGE OF RADIOLOGY®

# Certificate of Accreditation



## **RAYUS Radiology**

**537 Stonecrest Pkwy Ste 102  
Smyrna, Tennessee 37167**

**was surveyed by the ACR® Committee on MRI  
Accreditation of the Commission on Quality and Safety**

**The following magnet was approved**

**Hitachi Medical Corp.  
OASIS 2012**

**for**

**Head, MSK, Spine**

**Accredited from  
June 20, 2025 through October 07, 2028**

A stylized, handwritten signature in black ink, consisting of several loops and a long horizontal stroke.

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**Chair, Committee ON  
MRI Accreditation**

A handwritten signature in black ink that reads "David B. Fuson".

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**Chair, Commission on  
Quality and Safety**

Jennifer Mcgee  
RAYUS Radiology  
Attn: Jennifer McGee  
537 Stonecrest Pkwy Ste 102  
Smyrna, TN 37167



**State of Tennessee**  
**Health Facilities Commission**

502 Deaderick Street, Andrew Jackson Building, 9<sup>th</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-2364

**REGISTRATION OF MEDICAL EQUIPMENT**

Public Chapter 780, Acts of 2002, as amended, requires that owners of the following medical equipment register with the Tennessee Health Services and Development Agency: computerized axial tomographers, magnetic resonance imagers, linear accelerators, and positron emission tomography. Registration should occur within 90 days of acquisition.

Should you wish to provide information not specifically requested or further information with regard to information reported, please attach a separate page to provide such narrative.

**Correct As Is**                       **Correction**                       **New Facility with Equipment**

1. NAME AND ADDRESS OF PROVIDER

Tennessee Medical Imaging, P.C., dba RAYUS Radiology

(Name)

537 Stonecrest Pkwy Ste 102

(Street Address)

Rutherford

(County)

(Mailing Address, if different from Street Address)

Smyrna, TN 37167

(City)

(State)

(Zip)

615-890-8999

(Telephone Number)

Type of Provider:

ASTC       Hospital       Hospital Imaging Department (off site)       ODC

Physician's Office       Other (specify) \_\_\_\_\_

2. NAME AND ADDRESS OF OWNER OF HEALTH CARE PROVIDER

James Busch, M.D.

(Name)

537 Stonecrest Pkwy Ste 102

(Mailing Address)

Smyrna, TN 37167

(City)

(State)

(Zip)

615-890-8999

(Telephone Number)

3. CONTACT PERSON (Responsible for registration and utilization requests)

Jennifer McGee

(Name)

Tennessee Medical Imaging, P.C. dba  
RAYUS Radiology

(Company)

537 Stonecrest Pkwy, Ste 102

(Mailing Address)

Smyrna, TN 37167

(City)

(State)

(Zip)

Admin. Ops Mgr

(Title)

Jennifer.mcgee@rayusradiology.com

(Email Address)

615-890-8999

(Telephone Number)

615-890-6053

(Fax Number)

4. EQUIPMENT OWNERSHIP INFORMATION

**NOTE: Before you begin – the information below is required for each piece of equipment. If you have two or more of the same type of equipment, please copy this page for each, complete, and attach all pages to the first page of the Registration Form.**

A. CT:

Add Unit  Replacement Unit (Which unit is it replacing) \_\_\_\_\_

X Owned  Leased  Shared X Fixed Site  Mobile (Full)  Mobile (Part)

Number of Mobile/Shared Days in Use: \_\_\_\_\_ Days Per \_\_\_\_\_ (week,month,etc.)

Shared With and/or Leased By: \_\_\_\_\_

Date Acquired: 6/1/2019 Name Brand: Hitachi Supria

Initial Cost: \_\_\_\_\_ Serial No.: G560014418

Expected Useful Life (Yrs): 15 Assigned No.: \_\_\_\_\_

Scanner Type: X 16 Slice  40 Slice  64 Slice  128 Slice  Other \_\_\_\_\_

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B. Cyberknife/Gamma Knife/Proton Therapy:

(Check appropriate equipment)  Cyberknife  Gamma Knife  Proton Therapy

Add Unit  Replacement Unit (Which unit is it replacing) \_\_\_\_\_

Owned  Leased  Shared  Fixed Site

Shared With and/or Leased By: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Name Brand: \_\_\_\_\_

Initial Cost: \_\_\_\_\_ Serial No.: \_\_\_\_\_

Expected Useful Life (Yrs): \_\_\_\_\_ Assigned No.: \_\_\_\_\_

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C. Linear Accelerator:

Add Unit  Replacement Unit (Which unit is it replacing) \_\_\_\_\_

Owned  Leased  Shared  Fixed Site

Shared With and/or Leased By: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Name Brand: \_\_\_\_\_

Initial Cost: \_\_\_\_\_ Serial No.: \_\_\_\_\_

Expected Useful Life (Yrs): \_\_\_\_\_ Assigned No.: \_\_\_\_\_

MeV: \_\_\_\_\_  Single Energy  Dual Energy  Photon  Photon Electron

Special Types:  SRS  IMRT  IGRT  Other \_\_\_\_\_

E. MRI:

Add Unit  Replacement Unit (Which unit is it replacing) \_\_\_\_\_

X Owned  Leased  Shared X Fixed Site  Mobile (Full)  Mobile (Part)

Number of Mobile/Shared Days in Use: \_\_\_\_\_ Days Per \_\_\_\_\_ (week,month,etc.)

Shared With and/or Leased By: \_\_\_\_\_

Date Acquired: 6/1//2019 Name Brand: Hitachi (used) Oasis

Initial Cost: \$940,000 (pre-owned) Serial No.: M115

Expected Useful Life (Yrs): 20 Assigned No.: \_\_\_\_\_

Tesla Strength:  0.2  0.5  0.7  1.0  1.5  3.0 X Other 1.2

Magnet Type:  Breast  Closed  Extremity X Open  Short Bore  Other  
 Pediatric Only (14 years old and younger)  Adult Only X All Ages NOTE: Previously only adults, but with new registration allowance will begin using on all ages.

F. PET:

Add Unit  Replacement Unit (Which unit is it replacing) \_\_\_\_\_

Owned  Leased  Shared  Fixed Site  Mobile (Full)  Mobile (Part)

Number of Mobile/Shared Days in Use: \_\_\_\_\_ Days Per \_\_\_\_\_ (week,month,etc.)

Shared With and/or Leased By: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Name Brand: \_\_\_\_\_

Initial Cost: \_\_\_\_\_ Serial No.: \_\_\_\_\_

Expected Useful Life (Yrs): \_\_\_\_\_ Assigned No.: \_\_\_\_\_

Scanner Type:  PET Only  PET/CT Combination  PET/MRI Combination

G. Other:

Add Unit  Replacement Unit (Which unit is it replacing) \_\_\_\_\_

Owned  Leased  Shared  Fixed Site  Mobile (Full)  Mobile (Part)

Number of Mobile/Shared Days in Use: \_\_\_\_\_ Days Per \_\_\_\_\_ (week,month,etc.)

Shared With and/or Leased By: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Name Brand: \_\_\_\_\_

Initial Cost: \_\_\_\_\_ Serial No.: \_\_\_\_\_

Expected Useful Life (Yrs): \_\_\_\_\_ Assigned No.: \_\_\_\_\_

Equipment Description: \_\_\_\_\_

I hereby certify that this information is true to the best of my knowledge, information and belief, and that supplemental written notification will be filed with the Tennessee Health Services and Development Agency in the event of any change in the information given in this report.



Signature  
HF0047 (Revised 10/2022 – all forms prior to this date are obsolete)

12/22/2025

Date