Kentucky Board of Medical Imaging and Radiation Therapy

42 Fountain Place
Frankfort, KY 40601
Phone: (502)782-5687

For Office Use Only:

License Application- Medical Imaging or Radiation Therapy

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Social Security Number (last 4 digits): _____ Date of Birth: _____
Month *Day* *Year*

Fees

Medical Imaging or Radiation Therapy License:

☐ **Radiography**..... $100.00
(Graduate of JRCERT Accredited Program and ARRT Registered)

☐ **Nuclear Medicine** …….. $100.00
(Graduate of JRCNMT Accredited Program and ARRT or NMTCB Registered)

☐ **Radiation Therapist**…… $100.00
(Graduate of JRCERT Accredited Program and ARRT Registered)

☐ **Radiologist Assistant**……..$100.00
(Graduate of a JRCERT Accredited Radiography Program and ARRT Registered)

☐ **Nuclear Medicine Advanced Associate**……...$100.00
(Graduate of a JRCNMT Accredited Nuclear Medicine Program and NMTCB Registered)

Payments can be made by check or money order payable to: The Kentucky State Treasurer.

Eligibility

Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, please explain_____

Please submit the following documentations:

☐ **Government issued photo identification**

☐ **Results of criminal background check**

Pursuant to 201 KAR 46:040 applicants are required to submit "results of criminal background check completed within the past six (6) months in state of residence and employment and any other states of residence or employment within past five (5) years."

Have you previously applied for a Kentucky Medical Imaging or Radiation Therapy License? ☐ Yes ☐ No

If yes, Date: _____ Name applied under: _____

Have you previously been issued a license in another state(s)? ☐ Yes ☐ No If yes, please provide the following:

State: _____ License Number: _____

State: _____ License Number: _____

State: _____ License Number: _____

Employment Information

Place of Employment: _____

Business Address: _____
(Street, Road, or Box No.)

_____
City State Zip Code

Work Telephone Number: _____

A. In what type of facility are you currently employed?

☐ Hospital ☐ Clinic
☐ Private Office ☐ Mobile Health Service
☐ Unemployed ☐ Other: _____

Professional Certification/Registry

Pursuant to 201 KAR 46:040 documentation of active registration or certification with the ARRT or NMTCB is required.

A. **Please submit a copy of your ARRT or NMTCB certification.**

B. If applicable, please list all post primary certifications that you currently hold, and submit appropriate documentation for each.

_____

Education Information

A. Indicate the type of institution where you received your professional education:

☐ Hospital ☐ Vocation/Technical School ☐ Military
☐ Junior Community College ☐ University ☐ Other: _____

Please provide information about the educational program where you received your medical imaging or radiation therapy education

Name of educational institution: _____

Address: _____

Did you graduate from a JRCERT or JRCNMT accredited program? ☐ Yes ☐ No ☐ Unknown

Date of graduation: _____

B. Have you received a degree from a college/university? ☐ Yes ☐ No

If yes, check the highest degree received. ☐ *AA/AS* ☐ *BA/BS* ☐ *MA/MS* ☐ *Ph.D.*

Disclaimer and Signature

All applicants please read and sign/date the statement below. All applications will be null and void unless properly signed and dated.

I hereby submit this application and supporting documents and attest to the authenticity and accuracy of the application and all information contained herein. I further understand that if any information contained in this application or supporting documents submitted on my behalf, is determined to be false or misleading, this may be cause for denial, revocation or suspension of any license pursuant to this application and criminal prosecution and punishment.

Signature of Applicant: _____ Date: _____