



# Kentucky Board of Medical Imaging and Radiation Therapy

125 Holmes Street, Suite 320  
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 (if selecting more than one below, only one fee is required):

- Radiography..... \$100.00
- Nuclear Medicine ..... \$100.00
- Radiation Therapist..... \$100.00
- Radiologist Assistant.....\$100.00
- Nuclear Medicine Advanced Associate.....\$100.00

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

### Eligibility

Have you been convicted of a felony?  Yes  No If yes, please explain \_\_\_\_\_

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: \_\_\_\_\_

Has your license in another state(s) been denied, suspended, revoked, or otherwise disciplined?  Yes  No

If yes, please explain \_\_\_\_\_

Has your registration or certification with the ARRT or NMTCB ever been sanctioned, suspended, revoked or otherwise disciplined?  Yes  No

If yes, please explain \_\_\_\_\_

How many years of work experience do you have in medical imaging or radiation therapy? \_\_\_\_\_

Pursuant to KRS 12.245, are you a United States military service member or veteran?  Yes  No

## Employment Information

Place of Employment: \_\_\_\_\_

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

City State Zip Code

Work Telephone Number: \_\_\_\_\_ Work Email: \_\_\_\_\_

Start Date: \_\_\_\_\_ Title: \_\_\_\_\_

I am currently not employed as a medical imaging technologist or radiation therapist.

## Education Information

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

Select one:

Radiography  Nuclear Medicine  Radiation Therapist  Radiologist Assistant  Nuc Med Advanced Associate

Name of educational institution: \_\_\_\_\_

Address: \_\_\_\_\_

Date of graduation: \_\_\_\_\_

Additional educational information:

Not applicable

Radiography  Nuclear Medicine  Radiation Therapist  Radiologist Assistant  Nuc Med Advanced Associate

Name of educational institution: \_\_\_\_\_

Address: \_\_\_\_\_

Date of graduation: \_\_\_\_\_

## Required Documents

Please submit the following documentations with your application:

- Verification of graduation from education program(s) listed above;
- A copy of your ARRT or NMTCB certification;
- A copy of your government issued photo identification; and
- 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."*

## Disclaimer and Signature

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

I hereby submit this complete application and supporting documents and attest to its authenticity and the accuracy of the application and all information contained herein. I further understand that if any information contained in this application or the 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: \_\_\_\_\_