



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:

- 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 or a misdemeanor involving drugs, alcohol, fraud, deceit, falsification of records, a breach of trust, physical harm or endangerment to others, or dishonesty under the laws of any state or the United States [per KRS 311B.150 (4)(a)]? 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: _____

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? _____

Employment Information

Place of Employment: _____

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

City

State

Zip Code

Work Telephone Number: _____ Work Email: _____

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./Ed.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: _____