Kentucky Board of Medical Imaging and Radiation Therapy

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

For Office Use Only:

Temporary License Application- Medical Imaging & 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 Temporary License *VALID FOR ONE YEAR- NOT RENEWABLE*

☐ **Graduate of Medical Imaging or Radiation Therapy program**..... $100.00
(*Must be a JRCERT or JRCNMT Accredited Program)*

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 46:045 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: _____

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 or organization are you currently employed?

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

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: _____

Are you completing a JRCERT or JRCNMT accredited program? ☐ Yes ☐ No ☐ Unknown

Date of graduation: _____

Program Director Name (printed):_____

Program Director Signature: _____

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: _____