Kentucky Board of Medical Imaging and Radiation Therapy

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

For Office Use Only:

Limited X-Ray Machine Operator License Application

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

Limited X-Ray Machine Operator License

☐ **General (Kentucky)**..... $100.00

☐ **Podiatry (Kentucky)...**..... $100.00

☐ **Bone Densitometry (Kentucky)**..... $100.00

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 46:081 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 License? ☐ Yes ☐ No

If yes, Date: _____Name applied under: _____

Have you previously been issued any type of medical imaging license in another state? ☐ Yes ☐ No

If yes, what state: _____ License Number: _____

Employment Information

Place of Employment: _____

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

_____
City State Zip Code

Work Phone Number: _____

A. Are any medical imaging examinations that utilize contrast media (e.g. GI series, IVP, CT, MRI, etc.) performed at your place of employment?

☐ Yes ☐ No

B. Are any of the following performed at your place of employment:

☐ Yes ☐ No Mammography
☐ Yes ☐ No CT
☐ Yes ☐ No MRI
☐ Yes ☐ No Bedside Radiography
☐ Yes ☐ No Nuclear Medicine
☐ Yes ☐ No PET
☐ Yes ☐ No Radiation Therapy

Education Information

Please select the educational pathway completed for Limited Machine Operators:

☐ Formal Education Program

Name of Educational Institution: _____

Address: _____

Contact Phone Number: _____

Date of Completion: _____

☐ Independent Study Program

Name of Independent Study program: _____

Address: _____

Contact Phone Number: _____

Date of Completion: _____

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: _____