



**MEDICAL IMAGING OR RADIATION THERAPY LICENSEE REQUEST FOR UPDATE FORM**

Request:  Convert Temporary License to Permanent License  
 Add Post-Primary Certification(s) \_\_\_\_\_

For permanent license: Documentation of your ARRT or NMTCB certification must accompany this form.

Adding certification(s): Submit documentation of your ARRT or NMTCB post-primary certification(s).

Kentucky Board of Medical Imaging and Radiation Therapy  
125 Holmes Street, Suite 320  
Frankfort, KY 40601  
Ph. 502-782-5687  
Fax 502-782-6495  
Email [kbmirt@ky.gov](mailto:kbmirt@ky.gov)  
<https://kbmirt.ky.gov>

**Contact Information**

KY Radiation License No.: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*Last 4 Digits* *MM/DD/YYYY*

Full Name: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Employment Information**

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

Business Address: \_\_\_\_\_  
*Street, Road, or Box No.*  
\_\_\_\_\_  
*City State Zip Code*

Phone: \_\_\_\_\_ Work Email: \_\_\_\_\_

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date