125 Holmes Street, Suite 320
Frankfort, KY 40601
502-782-5687 Phone
502-782-6495 Fax
http://kbmirt.ky.gov

CONTACT INFORMATION FORM

Please include documentation of your ARRT or NMTCB certification.

For a name change: A copy of legal documents must accompany this form (i.e. Marriage License)

Contact Information

KY Radiation License Number: _____ Date of Birth:_____
(MM/DD/YY)

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:_____

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

_____ _____
Signature Date