



Kentucky Board of Medical Imaging and Radiation Therapy

2365 Harrodsburg Rd, Suite A220
Lexington, KY 40504
Phone: (502)782-5687

For Office Use Only:

License Application- Medical Imaging or Radiation Therapy

Applicant Information

Application for (select one): Initial License Reinstatement of Expired License (more than 12 mos)

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 (if selecting more than one discipline below, only one fee is required):

- 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.

In addition to the application fee, please include the following, if applicable:

- Reinstatement Fee..... \$100.00

Eligibility

Have you been convicted of a felony? Yes No If yes, please explain _____

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? _____

Pursuant to KRS 12.245, are you a member of the United States military, Reserves, or National Guard, or his or her spouse, or a veteran, or the spouse of a veteran? Yes No

Pursuant to KRS 311B.140, are you active duty in the United States Armed Forces? Yes* No

**If yes, please submit proof of active duty status, and licensure fees shall be waived.*

Employment Information

Place of Employment: _____

Business Address: _____

(Street, Road, or Box No.)

City

State

Zip Code

Work Telephone Number: _____ Work Email: _____

Start Date: _____ Title: _____

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

If you are on a travel assignment within the Commonwealth of Kentucky, please include your temporary employment information:

Not applicable

Place of Temporary Employment: _____

Business Address: _____

(Street, Road, or Box No.)

City

State

Zip Code

Work Telephone Number: _____ Work Email: _____

Start Date: _____ Title: _____

Education Information

Please provide information about the educational program(s) where you received your medical imaging or radiation therapy education.

Select one:

Radiography Nuclear Medicine Radiation Therapist Radiologist Assistant Nuc Med Advanced Associate

Name of educational institution: _____

Address: _____

Date of graduation: _____

Additional educational information:

Not applicable

Radiography Nuclear Medicine Radiation Therapist Radiologist Assistant Nuc Med Advanced Associate

Name of educational institution: _____

Address: _____

Date of graduation: _____

Required Documents

Please submit the following documentations with your application:

- Verification of graduation from education program(s) listed above;
- A copy of your ARRT or NMTCB certification;
- A copy of your government issued photo identification; and
- 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."

If you are applying for reinstatement of an expired license, in addition to the documents listed above, also submit the following:

- KBMIRT Form 8 that documents twenty-four (24) hours of approved continuing education

Disclaimer and Signature

All applicants please read, sign, and date the statement below. All applications will be null and void unless properly signed and dated.

I hereby submit this complete application and supporting documents and attest to its authenticity and the accuracy of the application and all information contained herein. I further understand that if any information contained in this application or the 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: _____