Kentucky Board of Medical Imaging and Radiation Therapy

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

For Office Use Only:

Temporary License Application - Student Radiography

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ _____
City *State* *ZIP Code*

Phone: _____ Email: _____

Social Security Number _____-_____-_____ Date of Birth: _____
Month *Day* *Year*

Fees

Student Radiography Temporary License * NON RENEWABLE*

☐ **Enrolled in accredited radiography program**……..$50.00

Payments can be made by check or money order payable to: The Kentucky State Treasurer.

Eligibility

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

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: _____

State: _____ License Number: _____

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

Start Date: _____ Title: _____

Work Telephone Number: _____

Manager's Name: _____ Manager's Email: _____

Education Information

Please provide information about the radiography educational program where you are enrolled:

Name of educational institution: _____

Address: _____

Expected date of program completion: _____

Program Director Name: _____ Email: _____

Required Documents

The following documentation are required to complete your application:

- ☐ **Verification of Student Status form;**
- ☐ **Employer Acknowledgement form;**
- ☐ **Official transcript sent directly from educational institution documenting academic progress;**
- ☐ **A copy of your government issued photo identification; and**
- ☐ **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."

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 have read and fully understand the limitations of the Temporary Student Radiography license, pursuant to 201 KAR 46:045, and further acknowledge that I shall notify the board immediately if I fail to maintain continuous enrollment, or if I am suspended, dismissed, or withdraw from the educational program.

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: _____

Kentucky Board of Medical Imaging and Radiation Therapy

2365 Harrodsburg Rd, Suite A220
Lexington, KY 40504
Phone: (502)782-5687
kbmirt@ky.gov

For Office Use Only:

Temporary License Application- Student Radiography
Verification of Student Status

Applicant Information

Applicant Full Name: _____
Last *First* *M.I.*

Social Security Number _____-_____-_____ Date of Birth: _____/_____/_____
Month *Day* *Year*

Education Information

PROGRAM DIRECTOR: Please complete the portion below and submit via email to KBMIRT@ky.gov

Name of educational institution: _____

Address: _____
Street Address *City* *State* *Zip*

Type of program: ☐ Associates ☐ Bachelors Anticipated Date of Completion: _____

Number of Credit Hours Required for Completion: _____

Number of Credit Hours Completed by Student: _____

Is the student in good standing with the educational institution: ☐ Yes ☐ No If no, please explain: _____

In accordance with 201 KAR 46:045 the applicant shall have completed at least fifty percent (50%) of the program with clinical experience in varied imaging procedures as endorsed by the program director. Please indicate, by signature, which areas the applicant has obtained documented clinical competency for static x-rays:

_____ Chest, Ribs, and Thorax

_____ Upper Extremities

_____ Lower Extremities

_____ Spine and Pelvis

_____ Abdomen

Comments: _____

_____

_____

By signing below, the program director attests to the accuracy and authenticity of the information above. The program director further certifies that the student has successfully completed at least fifty percent (50%) of the educational program and has demonstrated clinical competence in varied clinical procedures. Additionally, the program director agrees to promptly notify the board of any changes in the student's academic status.

Name of Program Director: _____ Title: _____

Telephone Number:_____ Email Address:_____

_____

Program Director's Signature *Date*

Student Disclaimer and Signature

APPLICANT: Sign and date the certification and authorization for release of information.

I authorize school/program officials to release the information requested to the Kentucky Board of Medical Imaging and Radiation Therapy for the purpose of determining eligibility for the temporary student radiography license.

Signature of Applicant: _____ Date: _____

Kentucky Board of Medical Imaging and Radiation Therapy

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For Office Use Only:

Temporary License Application- Student Radiography
Employer Acknowledgement

Applicant Information

Applicant Full Name: _____
Last *First* *M.I.*

Social Security Number _____-_____-_____ Date of Birth: _____/_____/_____
Month *Day* *Year*

Employment Information

EMPLOYEE'S MANAGER / DIRECTOR: Please complete the portion below and submit via email to KBMIRT@ky.gov

Place of Employment: _____

Business Address: _____
Street Address *City* *State* *Zip*

Manager's Name: _____ Manager's Email:_____

Title of Position: _____ Anticipated Start Date: _____

Type of employment: ☐ Full-Time ☐ Part-Time ☐ PRN

By signing below, the employer attests to the accuracy and authenticity of the information above. The employer further certifies that they have read and fully understand the restrictions on the temporary student radiography license, as provided in 201 KAR 46:045; and certifies that a licensed radiographer will provide supervision throughout employment.

_____
Manager's Signature *Date*

Student Disclaimer and Signature

APPLICANT: Sign and date the certification and authorization for release of information.

I authorize my employer to release the information requested to the Kentucky Board of Medical Imaging and Radiation Therapy for the purpose of determining eligibility for the temporary student radiography license.

Signature of Applicant: _____ Date: _____