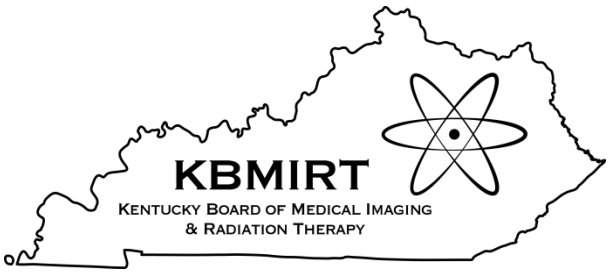

Kentucky Board of Medical Imaging and Radiation Therapy

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, placed on probation or otherwise disciplined? ☐ Yes ☐ No

If yes, please explain_____

Have you ever entered into an "Alternative Disposition Agreement" with the ARRT or NMTCB regarding a violation of the ARRT Rules and Regulations or Standards of Ethics? ☐ Yes ☐ No

If yes, please explain (attach copy of the agreement)_____

How many years of work experience do you have in medical imaging or radiation therapy? _____

Have you practiced as a medical imaging technologist or radiation therapist in Kentucky prior to being issued a license? (e.g. engaged or attempted to engage in the operation of radiation-producing equipment or the administration of ionizing radiation for the purpose of medical imaging or radiation therapy, manipulated equipment that produces ionizing radiation, or administered radiopharmaceuticals in Kentucky)? ☐ Yes ☐ No

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: _____