Kentucky Board of Medical Imaging and Radiation Therapy

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

For Office Use Only:

Limited X-Ray Machine Operator License Application

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

Limited X-Ray Machine Operator License (if selecting more than one license type below, only one fee is required):

☐ **General (Kentucky)**..... $100.00

☐ **Podiatry (Kentucky)...**..... $100.00

☐ **Bone Densitometry (Kentucky)**..... $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 ever been convicted of a felony? ☐ Yes ☐ No If yes, please explain (attach court documents): _____

_____

Have you previously been issued any type of medical imaging license in another state? ☐ Yes ☐ No

If yes, what state: _____ License Number: _____

Has your license in another state(s) been denied, suspended, revoked, or otherwise disciplined? ☐ Yes ☐ No

If yes, please explain_____

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: _____

A. Are any medical imaging examinations that utilize contrast media (e.g. GI series, IVP, CT, MRI, etc.) performed at your place of employment?

☐ Yes ☐ No

B. Are any of the following performed at your place of employment:

☐ Yes ☐ No Mammography
☐ Yes ☐ No CT
☐ Yes ☐ No MRI
☐ Yes ☐ No Bedside Radiography
☐ Yes ☐ No Nuclear Medicine
☐ Yes ☐ No PET
☐ Yes ☐ No Radiation Therapy

☐ **I am not currently employed as a Limited X-ray Machine Operator.**

Education Information

Please provide information about the education completed for Limited X-ray Machine Operators:

Name of Educational Institution: _____

Address: _____

Contact Phone Number: _____

Date of Completion: _____

Required Documents

Please submit the following documentations with your application:

- ☐ **Verification of graduation from education program(s) listed above;**
- ☐ **A copy of passing results of limited scope radiography examination;**
- ☐ **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."

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: _____