



# Kentucky Board of Medical Imaging and Radiation Therapy

125 Holmes Street, Suite 320  
 Frankfort, KY 40601  
 Phone: (502)782-5687

## License Renewal Application- Medical Imaging or Radiation Therapy

### Licensee Information

Application for (select one):  License Renewal  Reinstatement of Lapsed License (less than 12 mos)

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street Address Apartment/Unit #

\_\_\_\_\_  
City State ZIP Code

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

KY Radiation License Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Month Day Year

### Fees-Annual

Medical Imaging or Radiation Therapy License (if selecting more than one discipline below, only one fee is required):

- Radiography..... \$50.00
- Nuclear Medicine ..... \$50.00
- Radiation Therapist..... \$50.00
- Radiologist Assistant..... \$50.00
- Nuclear Medicine Advanced Associate..... \$50.00

*Payments can be made online during your renewal cycle at <http://kbmirt.ky.gov> or by submitting 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

### CE Attestation

If licensee is completing continuing education biennium, pursuant to 201 KAR 46:060 licensee is required "to complete twenty four (24) continuing education hours per biennium."

- As a licensee, pursuant to 201 KAR 40:060, I have completed the required continuing education hours.
- As a licensee, pursuant to 201 KAR 40:060, I am not at the end of my biennium and do not need to complete continuing education for this renewal.

*It is the responsibility of the licensee to maintain all continuing education documentation for current and prior biennium and submit documentation if selected for continuing education audit.*

## Employment Information

Current Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address*

\_\_\_\_\_

*City*

\_\_\_\_\_

*State*

\_\_\_\_\_

*ZIP Code*

Phone: (      )      -      Business email: \_\_\_\_\_

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

## Eligibility

Have you been convicted of a felony or a misdemeanor since your last renewal involving drugs, alcohol, fraud, deceit, falsification of records, a breach of trust, physical harm or endangerment to others, or dishonesty under the laws of any state or the United States [per KRS 311B.150 (4)(a)]?

Yes  No

If yes, please explain (attach court documents):

\_\_\_\_\_

Has your license in another state(s) been denied, suspended, revoked, or otherwise disciplined since your last renewal?

Yes  No  Not applicable

If yes, please explain \_\_\_\_\_

Is your ARRT or NMTCB certification or registration currently valid and active?  Yes  No

Has your registration or certification with the ARRT or NMTCB been reprimanded, revoked, or otherwise disciplined since your last renewal?  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.*

## Disclaimer and Signature

*All licensees please read, sign, and date the statement below. All license renewal forms will be null and void unless properly signed and dated.*

I hereby submit this complete renewal form and attest to its authenticity and the accuracy of the form 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: \_\_\_\_\_