
# 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- Medical Imaging & Radiation Therapy**

## Applicant Information

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 Temporary License *VALID FOR UP TO ONE YEAR- NOT RENEWABLE***

☐ **Graduate of Medical Imaging or Radiation Therapy program**.....$100.00

***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 United States military service member or veteran? ☐ Yes ☐ No

## 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.

## Education Information

Please provide information about the educational program 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: _____

**Your program director must complete the following and sign:**

By signing below, the program director confirms the individual applying for the Temporary Radiation license has completed or will complete all requirements for graduation and will notify the board of any changes in status of the individual's graduation date.

Date of graduation: _____

Program Director Name (printed): _____

Program Director Signature: _____ Date: _____

## Required Documents

**Please submit the following documentations with your application**:

☐ **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: _____