IOWA DEPARTMENT OF PUBLIC HEALTH, BUREAU OF RADIOLOGICAL HEALTH

LUCAS STATE OFFICE BUILDING, 5TH FLOOR, 321 EAST 12TH STREET, DES MOINES, IOWA 50319

APPLICATION RENEWAL FOR LIMITED NUCLEAR MEDICINE TECHNOLOGIST PERMIT TO PRACTICE

Your renewal application is sent approximately 45 days before your permit expires. If you have not received your renewal application from the IDPH, you may submit this application to renew your permit.

INSTRUCTIONS FOR COMPLETING THIS FORM:

Print or type the required information. 24.0 hours of continuing education is required within Biennium Date. Include copies of proofs of completion if this is the year you are required to report hours. Send the completed application and proof of CE hours (if applicable) and a nonrefundable $50 fee in a check or money order made payable to IDPH to: Iowa Department of Public Health, Bureau of Radiological Health Lucas State Office Building, 5th Floor, 321 East 12th Street, Des Moines, IA 50319

If you have any questions, please contact: *

Charlene Craig Phone: 515-281-0415 Email: charlene.craig@idph.iowa.gov

APPLICANT'S INFORMATION:

First Name: * _____

Middle Name: _____

Last Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip: * _____

Phone Number:* _____ Date of Birth: _____

Email: _____ SSN: * _____

Permit Number * _____

AFFIRMATION QUESTIONS:

During the previous licensing period, did you develop a medical condition, which in any way impairs or limits your ability to perform the duties of this profession? Medical Condition means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism. *
If yes, provide a description of your condition and submit a letter from a physician stating

Yes No

_____

During the previous licensing period, did you engage in the illegal or improper use of drugs or other chemical substances? *
If yes, provide a statement and a copy of relevant documentation including records from a physician or treatment program.

Yes No

_____

During the previous licensing period, where you convicted of, or entered a plea of no contest to a misdemeanor or felony crime? (Other than minor traffic violations with fines under $250). You must answer YES, if the court expunged the matter or the court deferred judgment.) *
If yes, include the date, location, charging orders, court disposition, and current status (i.e. probation) for each charge.

Yes No

_____

During the previous licensing period, did any state or other jurisdiction of the United States or any other nation limit, restrict, warn, censure, place on probation, suspend, revoke, or otherwise discipline a professional license, permit, registration, or certification issued to you? *
If yes, include the date, location, reason, and resolution.

Yes No

_____

During the previous licensing period, were there judgments or settlements paid on your behalf as a result of a professional liability case? *
If yes, include the date, location, reason, and resolution.

Yes No

_____

During the previous licensing period, did you have a license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body? *
If yes, provide a description of the circumstances.

Yes No

_____

EMPLOYER INFORMATION: (Use additional pages for employer information if necessary.)

Contact Type: * ☐ Current Employer ☐ No Employer ☐ Previous Employer

First Name: * _____ Last Name: * _____

Phone Number: * _____ Email Address: _____

Business Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip Code: * _____

Comments: _____

Contact Type: * ☐ Current Employer ☐ No Employer ☐ Previous Employer

First Name: * _____ Last Name: * _____

Phone Number: * _____ Email Address: _____

Business Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip Code: * _____

Comments: _____

OUT OF STATE LICENSES:

If you have a current, expired, or inactive permit or license in another state, please list the details below

State of Issuance: * _____ Type of License: * _____

License Number: * _____ License Expiration Date: * _____

NUCLEAR MEDICINE TECHNOLOGIST INFORMATION:

ARRT or NMTCB Registration Type: *	☐ ARRT ☐ NMTCB
ARRT or NMTCB Registration#:*	_____
Do you maintain current ARRT or NMTCB registration? *	☐ Yes ☐ No
ARRT or NMTCB Expiration Date: *	_____ (MM/DD/YY)
ARRT or NMTCB Biennium End Date: *	_____ (MM/DD/YY)

Privacy Act Notice: Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning my application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that I am required to update answers or information submitted herewith if the response or the information changes.

In submitting this application, I consent to any reasonable inquiry that may be necessary to verify or clarify the information I provided on or in conjunction with this application.

I understand that this information is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.

I have read the Administrative Rules governing this profession and I agree to comply with those provisions.

_____ _____

SIGNATURE OF APPLICANT DATE