

IOWA DEPARTMENT OF PUBLIC HEALTH, BUREAU OF RADIOLOGICAL HEALTH

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

APPLICATION FOR PERMIT TO PRACTICE RADIOLOGIST ASSISTANT

INSTRUCTIONS FOR COMPLETING THIS FORM:

Print or type the required information. Provide the appropriate document(s). Send the completed form, required documentation, and the nonrefundable fee of \$60 in a check or money order made payable to the 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: * _____

AFFIRMATION QUESTIONS:

Do you have a medical condition, which in any way currently 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. * Yes No

If yes, provide a description of your condition and submit a letter from a physician stating how your condition will affect your ability to perform the duties of this profession.

Have you, within the past 5 years, engaged in the illegal or improper use of drugs or other chemical substances? * Yes No

If yes, provide a statement and a copy of relevant documentation including records from a physician or treatment program.

Have you ever been 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

Has any state or other jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or otherwise disciplined a professional license, permit, registration, or certification issued to you? *
 If yes, include the date, location, reason, and resolution.

Yes No

Have there ever been 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

Have you ever had 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: * _____

CLASSIFICATION INFORMATION OF RADIATION THERAPIST:

Certification Organization: *	American Registry of Radiologic Technologists(ARRT)
ARRT Registration Type: *	_____
ARRT Registration#: *	_____
Do you maintain current ARRT registration? *	Yes No
ARRT Expiration Date: *	_____ (MM/DD/YY)
ARRT 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