

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 INDUSTRIAL RADIOGRAPHER EXAM

INSTRUCTIONS: Complete the Form. Mail the original and a \$175.00 non-refundable fee payable to Iowa Department of Public Health in accordance with Chapter 38.8(3)"a" of IDPH Radiation Machines and Radioactive Materials Rules to the above address. Incomplete or incorrect forms will be returned. Please type or print legibly.

If you have any questions, please contact:

Angela Leek, Bureau Chief- (515) 281-3478,

Stuart Jordan, Health Physicist-(515) 281-0403

APPLICANT'S INFORMATION:

First Name: * _____

Middle Name: _____

Last Name: * _____

Street Address: * _____

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

Phone Number: * _____, _____ Date of Birth: _____

Email: _____ SSN: * _____

INFORMATION DETAILS:

Agency Authorized Training :		
Completed the requirements of 641-45.1(10)"a" and 641-45.1(10)"b"	Yes	No
Certificate from 40-hour training	Yes	No
If Yes, Please Provide copy of Certificate/documentation.		
Completed written or oral exam covering topics in 641-45.1(10)"a" on	_____	(MM/DD/YY)

Additional Qualification Requirements :

If currently working for a radiography company, you must complete this section, and the RSO must sign this form

I am working for a Radiography Company* Yes No

Name of RSO _____

Radiography Company Name _____

Radiography Company License/Registration No _____

Mailing Address _____

Radiography Company Phone Number _____

Demonstrated competence using this company's sources of radiation on _____
(MM/DD/YY)

Type of Examination *:	Initial	Re-examination	Renewal
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Type of Certification(Select the Category of Exam) *:

Both (RAM & X-ray)	Radioactive Material Only (RAM)	X-ray Machines Only
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Trainer Status Requested, The individual listed above has met the requirements for radiographer trainer as indicated in 641-45.1(10)"c" and is authorized to receive a trainer card. Yes No

Preferred test date: _____ Alternate test date: _____

What address do you want the card mailed to?

	Company	Other Address
Address	_____	_____

For Renewal: (Provide a Copy of current Radiography Card.)

Card No: _____ Expiration Date: _____

CERTIFIED RADIOGRAPHER EXPERIENCE RECORD EXAMPLE:

*Years of Certified Radiography Experience (mm/dd/yy) thru (mm/dd/yy)	Name the Equipment Manufacturer	Print Name of Radiation Safety Officer Name of Company City/State
01/01/04-01/01/05	Amersham, Inc. SPEC, etc. Balteau, XMAS, Sperry, etc.	John Doe XYZ Industries, Inc. Racine, WI

To qualify as a trainer, document at least one year of experience as a certified radiographer.

*Years of Certified Radiography Experience (mm/dd/yy) thru (mm/dd/yy)	Name the Equipment Manufacturer	Print Name of Radiation Safety Officer Name of Company City/State

*Radiographer experience includes the use of sources of radiation, performance of radiation surveys and radiation safety related activities. Radiographer experience does not include film development and interpretation, darkroom activities, travel, safety meetings, classroom training and/or the use of cabinet x-ray units.

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.

CERTIFICATION:

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

Printed or Typed Name Applicant

Signature of RSO, Date

Printed or Typed Name of RSO