

**Iowa Department of Public Health, Bureau of Radiological Health**  
**Application for State of Iowa Permit to Practice**  
General Radiologic Technologist | Nuclear Medicine Technologist | Radiation Therapist

**Mailing Address:**

Send the following to the Mailing Address given:

**Iowa Department of Public Health  
Bureau of Radiological Health  
Lucas State Office Building, 5th Floor  
321 East 12th Street  
Des Moines, IA 50319**

- Your completed application.
- A **nonrefundable fee** in a check or money order payable to: **Iowa Department of Public Health.**
- Your transcript of CEU hours (if due.)

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**Questions?**

Customer Support Phone: 855-824-4357

Email: [adpereg@idph.iowa.gov](mailto:adpereg@idph.iowa.gov)

Internet Address: <https://idph.iowa.gov/regulatory-programs/permits-to-practice>

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**APPLICANT'S INFORMATION:** (Type or print the information below)  This is a new address

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_ SSN: \_\_\_\_\_

Have you held an Iowa Permit to Practice before? Y  N  Permit Number RAD \_\_\_\_\_

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**Reinstatement** - If you allow your permit to expire you will be required to apply for reinstatement, meaning you will need to pay the \$150 fee that would be charged for a new permit. You will also be subject to investigation for working without a permit.

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**Select Permit(s):** Your renewal application should be submitted approximately **45 days before** your permit expires.

(Mark your selection below for **any 1 single permit**)

**General Radiologic Tech**

**Nuclear Medicine Tech**

**Radiation Therapist**

Renewal \$75

Renewal \$75

Renewal \$75

Reinstatement \$150

Reinstatement \$150

Reinstatement \$150

New \$100

New \$100

New \$100

--OR--

(Mark your **combination** selections below)

**Renewal** Combination \$110  General Radiologic Tech  Nuclear Medicine Tech  Radiation Therapist

**New or Reinstatement** Combination \$150  General Radiologic Tech  Nuclear Medicine Tech  Radiation Therapist

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**AFFIRMATION QUESTIONS:**

**(New)** Do you have ...

**(Renewal)** 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.

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.

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**(New)** Have you, within the past 5 years, engaged ...

**(Renewal)** During the previous licensing period, did you engage ...

...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.

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**(New)** Have you ever been...

**(Renewal)** During the previous licensing period, were 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.)

Yes

No

If yes, include the date, location, charging orders, court disposition, and current status (i.e. probation) for each charge.

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**(New)** Has...

**(Renewal)** 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?

Yes

No

If yes, include the date, location, reason, and resolution.

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**(New)** Have there ever been...

**(Renewal)** During the previous licensing period, were there...

...judgments or settlements paid on your behalf as a result of a professional liability case?

Yes

No

If yes, include the date, location, reason, and resolution.

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**(New)** Have you ever had...?

**(Renewal)** During the previous licensing period, did you have...

...a license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body?

Yes

No

If yes, provide a description of the circumstances.

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**CLASSIFICATION INFORMATION:** (mark the box and fill in the information for the permit(s) you are applying for)

**General Radiologic Technologist**

**Radiation Therapist**

Certification Organization:	American Registry of Radiologic Technologists(ARRT)
ARRT Registration Type:	
ARRT Registration #:	
Do you maintain current ARRT registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ARRT Expiration Date:	_____ (MM/DD/YY)
ARRT Biennium End Date:	_____ (MM/DD/YY)

**Nuclear Medicine Technologist**

**Nuclear Medicine w/CT Endorsement**

Certification Organization:	<input type="checkbox"/> American Registry of Radiologic Technologists(ARRT) or <input type="checkbox"/> Nuclear Medicine Technologist Certification (NMTCB)
<input type="checkbox"/> ARRT or <input type="checkbox"/> NMTCB Registration Type:	
<input type="checkbox"/> ARRT or <input type="checkbox"/> NMTCB Registration#:	
Do you maintain current <input type="checkbox"/> ARRT or <input type="checkbox"/> NMTCB registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ARRT or <input type="checkbox"/> NMTCB Expiration Date:	_____ (MM/DD/YY)
<input type="checkbox"/> ARRT or <input type="checkbox"/> NMTCB Biennium End Date:	_____ (MM/DD/YY)

**I am submitting CEU's**

24 hours of continuing education is required at the end of your Biennium Date. **Include a copy of your transcript** showing all courses completed if this is the year you are required to report hours. If the educational organization you are working with does not have a transcript, please send copies of your certificates of completion.

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**EMPLOYER INFORMATION:** (leave blank if No Employer)

Current Employer	
Supervisor's Name:	_____
Phone Number:	_____ Email Address: _____
Business Name:	_____ Street Address: _____
City:	_____ State: _____ Zip Code: _____
Previous Employer (if current employer is less than 1 year)	
Supervisor's Name:	_____
Phone Number:	_____ Email Address: _____
Business Name:	_____ Street Address: _____
City:	_____ State: _____ Zip Code: _____
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: _____

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  
(REQUIRED)

\_\_\_\_\_  
Date