Reset Form

APPLICATION FOR RADIOLOGY LICENSE

State Form 27068 (R22 / 12-20)

INDIANA DEPARTMENT OF HEALTH
DIVISION OF RADIOLOGY AND WEIGHTS & MEASURES
2 North Meridian Street, 4 Selig
Indianapolis, IN 46204

* This agency is requesting disclosure of your Social Security number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

INSTRUCTIONS:

1. *Complete all sections. Missing information may delay processing.*
2. *Type or clearly print all information.*
3. *The fee for this license is $60.00 in accordance with IC 16-41-35 and 410 IAC 5.2. Make check or money order payable to the Indiana Department of Health.*
4. *If your name has changed since your enrollment in a radiography program, enclose a copy of proof of name change (marriage certificate, divorce decree, or court order stating the legal name change).*
5. *Mail the completed application and fee to the above address.*

THIS FORM CANNOT BE USED FOR LICENSE RENEWAL.

APPLICANT INFORMATION

First name	Middle initial	Last name

Home address *(number and street or P. O. Box)*	E-mail address *(for future license renewal notification)*

City	State	ZIP code

Social Security Number *(Required per IC4-1-8-1)* *	Daytime telephone number *(including area code)* ( )	Date of birth *(mm/dd/yyyy)*

LICENSE CATEGORY

- ☐ Cardiac Catheterization
- ☐ Chest
- ☐ Chiropractic
- ☐ Dental
- ☐ Nuclear Medicine
- ☐ Podiatric
- ☐ Radiation Therapy
- ☐ Radiologic Technologist

APPROVED EDUCATIONAL PROGRAM

Name of school / program	Date enrolled *(mm/dd/yyyy)*	Date graduated *(mm/dd/yyyy)*

Address of school / program *(number and street, city, state, and ZIP code)*

PROFESSIONAL INFORMATION

Check appropriate examination / certification you have completed:

- ☐ ARRT Limited Scope Examination
- ☐ ARRT Nuclear Medicine
- ☐ ARRT Radiation Therapy
- ☐ ARRT Radiography
- ☐ IPMA Program / Examination
- ☐ ASCT Chiropractic Examination
- ☐ Cardiac Catheterization Examination
- ☐ DANB Radiation Health and Safety
- ☐ NMTCB Nuclear Medicine

COMPLIANCE INFORMATION

Answer each of the following questions. For any "YES" answer to questions 1 - 4, please provide copies of legal documents of proceedings, corrective action, any probation with ending dates, and attach to the application.

1. Have you ever been convicted of a felony? ☐ Yes ☐ No
2. Have you ever been denied or had a license / certification revoked? ☐ Yes ☐ No
3. Have you ever been formally notified of any complaint against you relative to the practice of radiologic technology? ☐ Yes ☐ No
4. Do you have a drug or alcohol abuse problem or any mental or physical disability that, through the practice of your duties, may be dangerous to patients or public? ☐ Yes ☐ No
5. Are you a high school graduate or GED Certificate holder? ☐ Yes ☐ No

APPLICANT AGREEMENT

In consideration of the granting to me a license, I do hereby agree to abide by all the rules and regulations of the Indiana Department of Health and to permit the Department, or it's duly authorized representative, at all reasonable times, opportunity to inspect my license.

I also declare subject to the penalties for perjury, that all data appearing on this application is accurate and true to the best of my knowledge. I hereby authorize the release of any and all educational information concerning this application to the Indiana Department of Health.

Signature of applicant	Date signed *(mm/dd/yyyy)*

If you have any questions, call (317) 233-7565, Division of Radiology and Weights & Measures or e-mail radiology@isdh.in.gov.