



APPLICATION FOR RADIOLOGY LICENSE

State Form 27068 (R19 / 3-18)
Approved by State Board of Accounts, 2018

INDIANA STATE DEPARTMENT OF HEALTH
Attn: **Cashier's Office**
PO Box 7236
Indianapolis, IN 46207-7236

* 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 State 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			
<input type="checkbox"/> Cardiac Catheterization	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Chest	<input type="checkbox"/> Dental	<input type="checkbox"/> Podiatric	<input type="checkbox"/> 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:			
<input type="checkbox"/> ARRT Limited Scope Examination	<input type="checkbox"/> ARRT Radiography	<input type="checkbox"/> Cardiac Catheterization Examination	
<input type="checkbox"/> ARRT Nuclear Medicine	<input type="checkbox"/> IPMA Program / Examination	<input type="checkbox"/> DANB Radiation Health and Safety	
<input type="checkbox"/> ARRT Radiation Therapy	<input type="checkbox"/> ASCT Chiropractic Examination	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been denied or had a license / certification revoked?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been formally notified of any complaint against you relative to the practice of radiologic technology?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are you a high school graduate or GED Certificate holder?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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 State 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 State Department of Health.			
Signature of applicant			Date signed (mm/dd/yyyy)
If you have any questions, call AC (317) 233-7565, Division of Medical Radiology Services or e-mail radiology@isdh.in.gov.			