Reset Form

APPLICATION FOR PROFICIENCY CERTIFICATION FOR LIMITED RADIOGRAPHER

State Form 53194 (R3 / 4-15)

INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF MEDICAL RADIOLOGY SERVICES
2 North Meridian Street, 4 Selig
Indianapolis, IN 46204

*Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is required. 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. *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).*
4. *Mail the completed application and a copy of your diploma from the approved education program to the address above.*

1. APPLICANT INFORMATION
(1 – 3 must be completed by the applicant)

First name	Middle initial	Last name

Home address *(number and street or P. O. Box)*	E-mail address

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)*

2. PERMIT CATEGORY

(Select One)

☐ Cardiac Catheterization ☐ Chiropractic ☐ Podiatric
☐ Chest ☐ Dental

Provisional or student permit number	Expiration date of permit *(mm/dd/yyyy)*

3. APPROVED EDUCATIONAL PROGRAM
(Complete the information below for the ISDH approved limited radiographic program.)

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

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

4. CERTIFIER
(This section must be completed by the certifier.)

First name	Middle initial	Last name

Address *(number and street or P. O. Box)*

City	State	ZIP code

Telephone number *(including area code)* ( )	Degrees and Certifications

5. EVALUATION AND CERTIFICATION OF PROFICIENCY

☐ I instructed this applicant on the principles of radiation protection and operation of radiation machines prior to making radiographic exposures.

☐ I provided this applicant with clinical instruction on procedures included in the limited radiography license for which they are applying.

☐ I ensured this applicant was under direct supervision of an appropriate practitioner, licensed radiologic technologist or another licensed individual approved by the ISDH in order to assist and evaluate the student's performance in terms of positioning, radiation protection and radiographic image quality.

☐ This applicant has the proficiency and skill necessary to obtain this limited radiography license.

Signature of certifier	Date *(mm/dd/yyyy)*

Printed name of certifier

If you have any questions, call AC (317) 233-7565, Division of Medical Radiology Services or email radiology@isdh.in.gov.