Reset Form

APPLICATION FOR PROVISIONAL OR STUDENT PERMIT

State Form 54176 (R / 4-15)

INDIANA STATE DEPARTMENT OF HEALTH
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. Send the completed form to the address above.

APPLICANT INFORMATION

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)*

PERMIT CATEGORY *(Select One)*

- ☐ Student - Dental (CODA Accredited Program)
- ☐ Student - Nuclear Medicine
- ☐ Student - Radiation Therapy
- ☐ Student - Radiologic Technologist
- ☐ Provisional - Cardiac Catheterization Certificate
- ☐ Provisional - Chest
- ☐ Provisional - Chiropractic
- ☐ Provisional - Dental
- ☐ Provisional - Podiatric

APPROVED EDUCATIONAL PROGRAM

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

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

Signature of Program Director / Instructor	Date *(mm/dd/yyyy)*

COMPLIANCE INFORMATION

Answer each of the following questions. For any "YES" answer, 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 an 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

APPLICANT AGREEMENT

In consideration of the granting to me a permit, 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 its duly authorized representative, at all reasonable times, opportunity to inspect my permit.

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 email radiology@isdh.in.gov.