



QUALIFIED RADIATION PHYSICIST / INSPECTOR APPLICATION

State Form 8023 (R5 / 6-22)
INDIANA DEPARTMENT OF HEALTH

INSTRUCTIONS: 1. Please submit completed application, two (2) reference letters as outlined in requirements, and transcripts, diplomas, certification documentation, etc. For the category of Diagnostic Imaging Physicist, please submit a sample mammography evaluation report.

2. Send everything to: medicalradiology@isdh.in.gov
Or mail to:

Indiana Department of Health
Division of Radiology and Weights & Measures
2 North Meridian Street, 4 Selig
Indianapolis, IN 46204

Check appropriate categories you are applying for:		<input type="checkbox"/> Diagnostic Imaging Physicist
		<input type="checkbox"/> Health Physicist
		<input type="checkbox"/> Radiation Oncology Physicist
		<input type="checkbox"/> X-ray Machine Inspector
Name		
<input type="checkbox"/> Home address (number and street, city, state, and ZIP code)		
Home telephone number ()	E-mail address	
<input type="checkbox"/> Work address (number and street, city, state, and ZIP code)		
Work telephone number ()	E-mail address	

EDUCATION – Postsecondary				
Name of School	Location (City and State)	Dates Attended (month, day, year)	Major	Degree / Year Graduated

RELATED WORK EXPERIENCE Add additional pages if necessary.			
Employer	Job Title	Duties (Brief)	Dates – From / To (month, day, year)

QUALIFIED RADIATION PHYSICIST / INSPECTOR APPLICATION (continued)

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CONTINUING EDUCATION <i>List last ten (10) years. Add additional pages if necessary.</i>			
Course Name	Course Sponsor	CEU / CMU Earned	Dates Attended (month, day, year)

PROFESSIONAL ORGANIZATIONS AND CERTIFICATES <i>Add additional pages if necessary.</i>		
Organization Name (ABR, ABMP, etc.)	Date of Certification (month, day, year)	Board Eligible (if not certified)

REFERENCES <i>Send in at least two (2) reference letters from individuals that are able to verify work experience and professional qualifications.</i>		
Name	Address (City, State, ZIP code)	Telephone Number with Area Code and E-mail Address

AVAILABLE INSTRUMENTS	
Instrument	Calibration Date (month, day, year)

I hereby declare, subject to penalties for perjury, that all information appearing on this application is accurate and true to the best of my knowledge.	
Signature of applicant	Date (month, day, year)