Reset Form

APPLICATION FOR APPROVAL OF RADIOLOGY PROGRAM

State Form 53193 (R2 / 8-25)
INDIANA DEPARTMENT OF HEALTH

INSTRUCTIONS:
1. *Fill out all fields. If an item does not apply put "NA" in that field. Do not use abbreviations on this application.*
2. *Type or clearly print all information.*
3. *Send the completed application and program information via email to Radiology@health.IN.gov*
4. *If you have any questions please contact the IDOH Radiology Division at Radiology@health.IN.gov*

RADIOLOGY PROGRAM

Name of program		
Address *(number and street)*		
City	State	ZIP code
Telephone number ( )	FAX number ( )	E-mail address

SELECT CATEGORY OF PROGRAM(S)

☐ Dental ☐ Chest ☐ Cardiac Catheterization ☐ Chiropractic ☐ Podiatric

PROGRAM COORDINATOR

Name of program coordinator		Title of program coordinator	
Address *(number and street)*			
City		State	ZIP Code
Telephone number ( )	FAX number ( )	E-mail address	

ADDITIONAL INFORMATION REQUIRED

If your program is not approved by the ARRT, NMTCB, ADA, or CODA, you must submit a copy of the following information:

a. Detailed curriculum of your program
b. Overview of your program
c. Location of your program
d. Curriculum vitae and/or resume of all faculty showing credentials and educational and professional background
e. Description of clinical education and clinical evaluation system
f. Description of competency based evaluation system

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application, and all additional information submitted with it, are true, complete, and correct to the best of my knowledge.

Signature of Authorized Program Representative	Date *(month, day, year)*