**NORTH DAKOTA MEDICAL IMAGING AND RADIATION THERAPY BOARD OF EXAMINERS**
PO BOX 398 BISMARCK, ND 58502
701-425-0861 Fax 701-224-9824 info@ndmirtboard.com www.ndmirtboard.com

# APPLICATION FOR INITIAL STATE LICENSURE

**This application is to initially license or provide a temporary license or conditional license to those practicing medical imaging and radiation therapy in North Dakota.**

Complete the four-page application. Check or money order should be payable to **NDMIRTBE**. The Board cannot accept credit card payments or payment over the phone. Please do not staple or tape your payment to the application.

**OFFICE USE ONLY:** RECEIVED _____ AMOUNT _____ CHECK # _____

Please check the discipline(s) in which you are currently **REGISTERED** and wish to apply for licensure:

___ Radiographer
___ Radiation Therapist
___ Radiologist Assistant
___ Other _____
___ Nuclear Medicine Technologist
___ Sonographer
___ Registered Cardiovascular Invasive Specialist

**Initial License:** ____ $25 Application Fee ____ $150 License Fee

The Board may issue an initial license to an applicant who is currently registered with a national certifying body.

**A temporary or conditional license may be issued at the discretion of the Board. If you wish to request a temporary or conditional license, you must send a written request with your application and fee.**

Temporary License: The Board may issue a temporary license for no longer than 180 days to an individual: 1) whose licensure may be pending OR 2) who will be practicing medical imaging or radiation therapy services to medically underserved areas as determined by the board.

Conditional License: The Board may issue a conditional license to an individual that graduated from a program and is actively working to fulfill requirements for registry. You must submit a copy of the program completion certificate.

**Contact Information:**
**Please complete the following information. Please print legibly or type the information. Do not use pencil!**

Name_____
First Middle Last Maiden

Mailing Address _____
PO Box or Street Address City State Zip

Home Phone ( ) _____ E-mail Address _____

Social Security Number _____ Date of Birth _____
(Failure to provide your social security number is a basis to deny a license. Federal law, 42 U.S.C. § 666(a)(13)(A), requires state professional and occupational licensing authorities to obtain all applicants' social security numbers and report these numbers to the state's child support enforcement authority. We will keep your social security number confidential, except when required to provide it according to state or federal law.)

Citizenship: _____ U.S. _____ Other, please list _____
(8 U.S.C. § 1621 requires proof of legal presence in the United States. **Acceptable documents include a copy of your birth certificate, or Social Security Card, US passport, foreign VISA or permission to work in the US. A driver's license is NOT an acceptable document to show citizenship.** If you have alien status, please contact the Board office for additional acceptable documents.)

**Employer Information**

Employer _____ Employer Phone ( ) _____

_____

Employer Address

_____

Employer City State Zip County

**Locums Tenens (Travelers)**

Are you currently working as a locum tenens (one who travels, sometimes to different states, to work for short periods of time in someone's absence or a shortage of employees)? ____ YES _____ NO

If YES, Company Name _____

Address _____

Address City State ZIP

Phone ( ) _____

How long will you be practicing in ND? _____

Name of ND facility: _____ City: _____

**Education and Training Information – You do not need to provide transcripts or diplomas to the Board.**

High School _____ Location (City/State) _____ Year _____

Please list the college or institution where you received your Medical Imaging Education:

College _____ Location (City/State) _____

Degree/Certificate _____ Major _____ Date _____

**Certification**

List ALL categories for which you are certified:_____

_____

(Examples: Mammography, CT, Magnetic Resonance Imaging, Quality Management, Sonography, Radiation Therapy, Radiologist Assistant, etc.)

*If sonography, list type* _____

(Examples: Abdomen (AB), Breast (BR), Adult Echo (AE), Pediatric Echo (PE), Vascular Technology (VT), etc.)

List below ALL disciplines in which you currently practice in but are not certified:

_____

(Examples: CT, MRI, Nuclear Medicine, Sonography, Mammography, Echo, Interventional, etc.)

| Modality | Place of Employment | On-the-job Training (Y/N) |
|---|---|---|
| _____ | _____ | _____YES _____NO |
| _____ | _____ | _____YES _____NO |
| _____ | _____ | _____YES _____NO |

**Credentialing**

**You must be currently registered in all areas you are currently practicing in. Please submit a copy of your registration card(s). If you have renewed your registration and have not received the new card, a copy of the verification of your status from the registry's website is acceptable. When you receive your new card, please send it to the Board office.**

Mark all that apply:

| | Registry Number | Expiration Date | CE Compliant |
|---|---|---|---|
| ARRT | _____ | _____ | _____YES _____NO |
| ARDMS | _____ | _____ | _____YES _____NO |
| NMTCB | _____ | _____ | _____YES _____NO |
| CCI | _____ | _____ | _____YES _____NO |
| CBRPA | _____ | _____ | _____YES _____NO |
| ARMRIT | _____ | _____ | _____YES _____NO |
| Other | _____ | _____ | _____YES _____NO |

**If you answered NO to CE compliance, please provide an explanation. You are not eligible for licensure if you are not currently registered and/or CE compliant.**

Are you currently licensed in any other states? _____ YES _____ NO

If YES, which states_____

**Personal Background History – You must answer these questions or your application will be returned!**

Criminal history, alcohol/drug abuse, mental health issues or disciplinary action is not necessarily a disqualification from licensure.

1. Have you ever been convicted of an offense other than minor traffic violations? _____ YES _____ NO
   (Offenses include any felonies or misdemeanors including under age in possession of alcohol (ages 18-21), DUI, drug possession, trespassing, assault, disorderly conduct, and theft.)

2. Do you have any pending disciplinary investigations, or have you ever had any other professional license subject to disciplinary action in North Dakota, or another state, or by any licensing agency? _____ YES _____ NO

3. Has any state rejected your application for certification or licensure? _____ YES _____ NO

4. Has any state revoked, suspended, refused to renew, or otherwise restricted your certification or license? _____ YES _____ NO

5. Have you ever abused alcohol or drugs or experienced any mental health difficulties which could impair your ability to practice Medical Imaging or Radiation Therapy? _____ YES _____ NO

6. Have you ever voluntarily surrendered your certificate or license in order to avoid disciplinary action by a regulatory agency? _____ YES _____ NO

*****If you have answered "YES" to any of the above background questions, you must provide the Board with a Letter of Explanation with the date and your signature. Your letter should include important dates, locations (if necessary), the surrounding circumstances, and the penalty, conviction, or treatment you received. You must also provide copies of all related documentation such as criminal judgments. All persons with a conviction in the last 5 years should also provide a copy of the ethics letter from their certifying body (ARRT, ARDMS, etc.). Failure to submit appropriate documentation may delay your license.

**Please review before submitting your application:**

Have you included the following?

_____A completed and signed four-page application
_____A check or money order payable to NDMIRTBE for the correct amount
_____A copy of your current registration with a national certifying agency (ARRT, ARDMS, etc.)
_____A copy of your citizenship documentation (Social Security Card, US Passport, US birth certificate, foreign VISA or permission to work in the US)
_____If you answered "Yes" to any of the questions in the Personal Background History, an explanation and any relevant documentation as requested at the end of that section
_____If applying for a conditional license, a copy of an official transcript of completing a program

**Agreement**

Please read the agreement carefully before signing.

In consideration of my receiving a permanent license from the North Dakota Board of Medical Imaging and Radiation Therapy Board of Examiners, I do hereby agree to abide by North Dakota laws and administrative rules pertaining to the practice of Medical Imaging and Radiation Therapy. (NDCC 43-62)

I AM AWARE THAT IF ANY CHANGES OCCUR IN MY EMPLOYMENT AND/OR HOME ADDRESS AND PHONE NUMBER, THE BOARD MUST BE NOTIFIED.

Falsifying an application, supplying misleading information or withholding information may be grounds for denial or revocation of licensure. By signing this application below, I certify that the information appearing on this application is accurate and true to the best of my knowledge.

_____ _____

Signature of Applicant Date

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PLEASE RETURN THE ***COMPLETED 4-PAGE APPLICATION AND APPROPIATE PAYMENT***, TO THE ADDRESS BELOW:

NDMIRTBE
PO 398
BISMARCK, ND 58502

Checks should be payable to NDMIRTBE.

If you have any questions, contact the Board office at 701-425-0861 or info@ndmirtboard.com.