

**IOWA DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF RADIOLOGICAL HEALTH**

**NUCLEAR MEDICINE "PERMIT TO PRACTICE" APPLICATION**

Instructions for completing this form:

1. Print or type the required information and provide the appropriate document(s) indicated below.
2. Send the completed form and a \$60.00 initial fee in a check or money order made payable to:  
Iowa Department of Public Health, Bureau of Radiological Health  
Lucas State Office Building, 5<sup>th</sup> Floor, 321 East 12<sup>th</sup> Street, Des Moines, IA 50319

If you have any questions, please contact: Charlene Craig (515) 281-0415; e-mail: charlene.craig@idph.iowa.gov

---

A.

Applicant's Name: \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Home Mailing Address: \_\_\_\_\_ email address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

High School Graduate                       GED Certification

---

B.

ARRT Reg. # \_\_\_\_\_ NMTCB #: \_\_\_\_\_

Please provide a copy of the ARRT card or NMTCB card as proof that you have passed the ARRT or NMTCB certification test. Current membership in the ARRT or NMTCB is not required. For NMTCB certification only, please provide a copy of proof of completion of a formal training program in addition to the NMTCB certification.

---

If you have a current, expired, or inactive permit or license in another state, please provide the state and type of permit/license: \_\_\_\_\_

---

---

C.

Current Employer in nuclear medicine: \_\_\_\_\_ Phone number: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If you are not currently working in nuclear medicine, please provide the name and address of your last nuclear medicine employer and the dates of your employment:

Date: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer address: \_\_\_\_\_

1. Do you have a medical condition(s) which in any way impair or limit your ability to perform under a permit issued by this application? "Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism. [ ]yes [ ]no

*If yes, provide a description of your condition and submit a letter from a physician stating that your condition will not affect your ability to perform as a permit holder.*

2. Have you within the past 5 years engaged in the illegal or improper use of drugs or other chemical substance? [ ]yes [ ]no

*If yes, provide a letter from your physician or treatment program that identifies your current or past treatment status. The letter should also include a statement that your condition will not affect your ability to perform as a permit holder.*

3. Have you ever been convicted of, or entered a plea of no contest to a misdemeanor or felony? (other than minor traffic violations with fines under \$100). You must answer "yes" even if the matter has been expunged from the record. [ ]yes [ ]no

*If yes, include the date, location, charge, court disposition and current status (i.e. probation) for each charge. If the charge was a crime against a person (i.e. assault, domestic abuse) include copies of the charging orders and court disposition records.*

4. Has any state or jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or otherwise disciplined a professional license or certification issued to you? [ ]yes [ ]no

*If yes, include date, location, reason, current status, etc.*

5. Have you professional suits ever been filed against you as a result of your performance as a diagnostic radiographer, nuclear medicine technologist, radiation therapist, or radiology assistant? [ ]yes [ ]no

*If yes, include the date, location, reason, resolution, etc.*

6. Have any judgments or settlements been paid on your behalf as a result of a professional liability case? [ ]yes [ ]no

*If yes, include the date, location, reason, resolutions, etc.*

7. Have you ever had a license or permit suspended or revoked from a state or certification body? [ ]yes [ ]no  
*If yes, provide a description of the circumstances.*

---

**Privacy Act Notice:** Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

- 
- 1. I will allow a representative of the Iowa Department of Public Health to comprehensively evaluate whether or not I meet the training standards if necessary.
  - 2. I understand this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.
  - 3. I understand that submitting false information on this application may result in revocation of the permit.
  - 4. I will not perform procedures differing from the categories that I have applied for.
  - 5. The information provided on this form and enclosure(s) is truthful and accurate.

---

Signature of Applicant

---

Date

Guidelines to continuing education can be found on our website: [idph.state.ia.us/idphradhealth/permitstopractice.aspx](http://idph.state.ia.us/idphradhealth/permitstopractice.aspx)