

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

“PERMIT TO PRACTICE” APPLICATION Revised 1-2013
RADIOLOGIST ASSISTANT

Instructions for completing this form:

1. Print or type the required information. Provide the appropriate document(s).
2. Send the completed form, required documentation, and the nonrefundable fee of \$60 in a check or money order made payable to the IDPH to:

Iowa Department of Public Health, Bureau of Radiological Health
Lucas State Office Building, 5th Floor, 321 East 12th Street, Des Moines, IA 50319

If you have any questions, please contact: **Charlene Craig 515/281-0415; or www.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 #: _____

B.
***Please include a copy of proof of a passing score on ARRT or equivalent examination for Radiologist Assistant.
Current membership is not required.

If you have a current, expired, or inactive permit or license in another state, please list the state and type of
license: _____

C.
Current Employer : _____ Phone number _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

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

Date: _____ Employer: _____

Employer address: _____

D.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.

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- 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
2/2013

Date