IOWA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF RADIOLOGICAL HEALTH

PERMIT TO PRACTICE RENEWAL APPLICATION
GENERAL RADIOLOGIC TECHNOLOGIST
NUCLEAR MEDICINE TECHNOLOGIST
RADIATION THERAPIST

Your renewal application is sent approximately 45 days before your permit expires. If you have not received your renewal application from the IDPH, you may submit this application to renew your permit.

Instructions for completing this form:

1. Print or type the required information.
2. 24.0 hours of continuing education is required every 2 years. Include copies of proofs of completion if this is the year you are required to report hours.
3. Send the completed application and proof of CE hours (if applicable) and a nonrefundable $50 fee in a check or money order made payable to 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; www.charlene.craig@idph.iowa.gov

Applicant's Name: _____ Home Phone Number _____

Home Mailing Address: _____ email address _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Current permit to practice number _____

Permit application for : [ ] general diagnostic [ ] nuclear medicine [ ] radiation therapy

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.

Current Employer in radiography: _____

Phone number _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

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 x-ray equipment operator in podiatric radiography?
[ ]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.

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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 Date Revised 1-2013