

**Iowa Department of Public Health
Bureau of Radiological Health
Lucas State Office Building
Des Moines, Iowa 50319-0075**

Application for Radon Measurement Certification

Name of Individual or Company	*Social Security No.:
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Location (street, state, zip code): _____

Person to Contact for Further Information	Phone:
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Name: Reason for Application: (Check one)	Date of Birth: (mm/dd/yy)
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New Certification Renewal	Owner (s) of the Company: (if different from above) Address:
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<p>Fee Schedule</p> <p>1. Certification Level (choose one)</p> <p>Laboratory (\$500) _____ Specialist (\$250) _____</p> <p>2. Application Fee</p> <p>Iowa Resident (\$25) _____ Non-resident (\$100) _____</p> <p>3. Total Fee _____</p>	<p>Testing Methods Used:</p> <p>____ AT – Alpha-Track Detection</p> <p>____ CC – Activated Charcoal Adsorption</p> <p>____ CR – Continuous Radon Monitor</p> <p>____ CW – Continuous Working Level Monitor</p> <p>____ EL – Electret-Perm (Long-term)</p> <p>____ ES – Electret-Perm (short-term)</p> <p>____ LS – Charcoal Liquid Scintillation</p> <p>____ RP – Radon Progeny Integrated Sampling</p> <p>____ SC – 3-Day Integrated Evacuation Scint. Cell</p> <p>____ UT – Unfiltered Alpha-Track Detection</p> <p>____ Other (explain) _____</p>
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Required:

1. Do you have a medical condition(s) which in any way may impair or limit your ability to perform as a radon tester? ___ 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 radon tester.

2. Have you within the past 5 years engaged in the illegal or improper use of drugs or other chemical substance(s)? ___ yes ___ no
If yes, provide a letter from your physician or treatment program that identifies your current or past treatment status.

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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 and current status.
5. Have you ever been found guilty of incompetence or negligence during your performance as a professional service provider? ___ yes ___ no
If yes, please explain.
6. Have you ever been sued as a professional service provider? ___ yes ___ no
If yes, please explain.

1. I have enclosed a check or money order payable to the Iowa Department of Public Health.
2. I have enclosed the additional information required in Parts A and B, as applicable.
3. I hereby certify that all information in this application is true and complete.
4. I understand that all statements and representations made with this application are binding upon the applicant.

Typed/Printed Name	Title
Signature of Applicant	Date

*Privacy Act Notice: Disclosure of your Social Security number on this license application is required by 42 U.S.C. Section 666(a)(13) and Iowa Code Section 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.

