Iowa Department of Health & Human Services, Bureau of Radiological Health

Application to Add a Classification to an Existing General Radiologic Technologist, Nuclear Medicine Technologist, or Radiation Therapist Permit to Practice

---

Instructions for completing this form:

Print or type the required information. Provide the appropriate document(s). Send the completed form and the fee indicated below in a check or money order made payable to: Iowa Department of Health and Human Services, Bureau of Radiological Health Lucas State Office Building, 5th Floor, 321 East 12th Street, Des Moines, IA 50319

*****Please include a copy of proof of a passing score on ARRT or NMTCB examination*****

To add General Diagnostic Technologist:

Submit this application, a copy of proof of passing the ARRT General Diagnostic Radiography certification exam, and the nonrefundable $40 amendment fee to the address above.

To add Nuclear Medicine Technologist:

Submit this application, a copy of proof of passing the ARRT or NMTCB Nuclear Medicine Technologist certification exam, and the nonrefundable $40 amendment fee to the address above.

To add Radiation Therapist:

Submit this application, a copy of proof of passing the ARRT radiation therapy certification exam, and the nonrefundable $40 amendment fee to the address above.

If you have any questions, please contact:

Matthew Millard: 515-371-9398 Email: matthew.millard@idph.iowa.gov

Internet Address: https://hhs.iowa.gov/regulatory-programs/permits-to-practice

---

Category to be added:

☐ General Diagnostic Technologist ☐ Radiation Therapist

☐ Nuclear Medicine Technologist ☐ CT Endorsement (*Nuc Med*)

APPLICANT'S INFORMATION: ***(****Type or print the information below* ***ALL*** *information below.* ***ALLinformation is need to process application!****)*

First Name:_____ Middle Name: _____

Last Name: _____

Street Address: _____

City:_____ State:_____ Zip: _____

Phone Number:_____ Date of Birth: _____

Email:_____ SSN:_____

Have you held an Iowa Permit to Practice before? Y ☐N ☐ Permit Number RAD _____

AFFIRMATION QUESTIONS ***(Please use additional paper if you need to respond to a 'Yes' response):***

During the previous licensing period, did you develop a medical condition, which in any way impairs or limits your ability to perform the duties of this profession? 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 how your condition will affect your ability to perform the duties of this profession.

During the previous licensing period, did you engage in the illegal or improper use of drugs or other chemical substances? ☐ Yes ☐ No

If yes, provide a statement and a copy of relevant documentation including records from a physician or treatment program.

During the previous licensing period, where you convicted of a misdemeanor or felony crime? (You do not need to answer yes if your sole conviction or convictions are for minor traffic violations with fines under $250). In answering this question, note that a conviction means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. This means you must answer yes if a finding or verdict of guilt was returned against you in a criminal proceeding or if you plead guilty, entered a plea of nolo contendere, or entered an Alford plea in a criminal proceeding, even if the court expunged the matter or the court deferred judgment. You must submit the complaint and judgment of conviction for each offense. ☐ Yes ☐ No

If yes, include the date, location, charging orders, court disposition, and current status (i.e. probation) for each charge.

During the previous licensing period, did any state or other jurisdiction of the United States or any other nation limit, restrict, warn, censure, place on probation, suspend, revoke, or otherwise discipline a professional license, permit, registration, or certification issued to you? ☐ Yes ☐ No

If yes, include the date, location, reason, and resolution.

During the previous licensing period, were there judgments or settlements paid on your behalf as a result of a professional liability case? ☐ Yes ☐ No

If yes, include the date, location, reason, and resolution.

During the previous licensing period, did you have license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body? ☐ Yes ☐ No

If yes, provide a description of the circumstances.

CLASSIFICATION INFORMATION: (mark the box and fill in the information for the permit(s) you are applying for addition toyour current Permit to Practice)

☐ **General Radiologic Technologist** ☐**Radiation Therapist**

Certification Organization:	American Registry of Radiologic Technologists(ARRT)
ARRT Registration Type:	
ARRT Registration #:	
Do you maintain current ARRT registration?	☐ Yes ☐No
ARRT Expiration Date:	_____ (MM/DD/YY)
ARRT Biennium End Date:	_____ (MM/DD/YY)

☐ **Nuclear Medicine Technologist** ☐**Nuclear Medicine w/CT Endorsement**

Certification Organization:	☐ American Registry of Radiologic Technologists(ARRT) or ☐ Nuclear Medicine Technologist Certification (NMTCB)
☐ ARRT or ☐NMTCB Registration Type:	
☐ ARRT or ☐NMTCB Registration#:	
Do you maintain current ☐ARRT or ☐NMTCB registration?	☐ Yes ☐No
☐ ARRT or ☐NMTCB Expiration Date:	_____ (MM/DD/YY)
☐ ARRT or ☐NMTCB Biennium End Date:	_____ (MM/DD/YY)

EMPLOYER INFORMATION: (leave blank if No Employer)

Current Employer

Supervisor's Name: _____

Phone Number:_____ Email Address: _____

Business Name:_____ Street Address: _____

City:_____ State:_____ Zip Code:_____

Previous Employer (if current employer is less than 1 year)

Supervisor's Name: _____

Phone Number:_____ Email Address: _____

Business Name:_____ Street Address: _____

City:_____ State:_____ Zip Code:_____

OUT OF STATE LICENSES

If you have a current, expired, or inactive permit or license in another state, please list the details below

State of Issuance:_____ Type of License: _____

License Number:_____ License Expiration Date: _____

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.

I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning my application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that I am required to update answers or information submitted herewith if the response or the information changes.

In submitting this application, I consent to any reasonable inquiry that may be necessary to verify or clarify the information I provided on or in conjunction with this application.

I understand that this information 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.

I have read the Administrative Rules governing this profession and I agree to comply with those provisions.

_____ _____

Signature of Applicant (REQUIRED) Date