Public Health
IOWA HHS

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

APPLICATION FOR PODIATRIC X-RAY EQUIPTMENT OPERATOR EXAMINATION

INSTRUCTIONS FOR COMPLETING THIS FORM:

Print or type the required information. Send the completed form and $100 nonrefundable examination fee 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

If you have any questions, please contact:

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

APPLICANT'S INFORMATION:

First Name: _____

Middle Name: _____

Last Name: _____

Street Address: _____

City:_____State:_____Zip: _____

Phone Number:_____Date of Birth: _____

Email:_____SSN Number: _____

Clinical Training Site: _____

AFFIRMATION QUESTIONS: All questions must be answered.

Do you have a medical condition, which in any way currently 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.

Have you, within the past 5 years, engaged in the illegal or improper use of drugs or other chemical substances?

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

Yes No

Have you ever been convicted of, or entered a plea of no contest to a misdemeanor or felony crime? (Other than minor traffic violations with fines under $250). You must answer YES, if the court expunged the matter or the court deferred judgment.)

Yes No

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

Has any state or other 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, permit, registration, or certification issued to you?

Yes No

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

Have there ever been judgments or settlements paid on your behalf as a result of a professional liability case?

Yes No

Please provide responses to "Yes" questions on a separate piece of paper(s).

EMPLOYER INFORMATION: (Use additional pages for employer information

Contact Type (circle one): Current No Employer Previous Employer

First Name:_____Last Name: _____

Phone Number:_____Email Address: _____

License Number:_____Business Name: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Contact Type (circle one): Current No Employer Previous Employer

First Name:_____Last Name: _____

Phone Number:_____Email Address: _____

License Number:_____Business Name: _____

Street Address: _____

City:_____State:_____Zip Code: _____

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 mis- leading 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 ap- plication 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 DATE

Ensure that all documentation of proof of completion of the didactic and clinical education is included.

Application, fees, and required documentation should be sent 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