APPLICATION FOR RADIOLOGIC TECHNOLOGIST

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure or renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

Are you requesting a Temporary Permit? (Temporary Permits are not issued to applicants by endorsement). Y ☐ N ☐

1. Indicate your full legal name. If your name is different from that shown on your documentation you must submit a copy of the legal document of name change.

Full Name: ____
first middle last suffix

Other names used, including maiden name: ______________________________

2. Include residence, mailing and e-mail address. Residence address may *not* be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A. 75-451 *et seq.* may use substitute residential and mailing addresses.

Residence Address: ____
street city county state zip

Mailing Address: ____
public information street city county state zip

E-mail: ____

3. Daytime phone number (include area code): ______________________

4. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number. K.S.A. 74-139 requires disclosure of your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq.* Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Date of Birth: ____________ Place of Birth: ______________________ Sex: M ☐ F ☐
city state/jurisdiction country

Social Security/Tax ID. No: ____________ NPI (National Provider Identifier): ____________ NPI Not Applicable: ☐

Are you a U.S. Citizen? Y ☐ N ☐ If you answered NO, are you (check one):

A qualified alien (as defined in 8 U.S.C.A. § 1641). ☐

A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 *et seq*). ☐

An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year. ☐

A foreign national, not physically present in the United States. ☐

Other: ____

5. List all Board (ARRT or NMTCB) examination attempts. Request an official copy of your ARRT or NMTCB scores be sent directly to the board and enclose a notarized copy of your current ARRT or NMTCB card.

I have not yet tested. ☐ Date scheduled to sit for the examination: ____________

Date ____________ Passed ____________ Number of attempts for initial testing.

6. List all post secondary schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. Enclose or send only an <u>official and final</u> transcript showing the degree awarded required for licensure. Do not provide additional education transcripts.

School Name: ____

Address: ____
street city state zip country

Attendance Dates: ____________ To ____________ Degree: ____________
month year month year

School Name: ____

Address: ____
street city state zip country

Attendance Dates: ____________ To ____________ Degree: ____________
month year month year

7. List all employment/professional activity during the past five years. Account for all time and explain <u>all</u> gaps in professional activity. Attach an additional sheet if necessary. <u>Include actual work address</u>, not corporate headquarters.

I have not been employed during the past five years. ☐

Employer: ____________________ Job description/Title ____________________

Address: ____________________ Dates: From ____________ To ____________
street city state mm/yy mm/yy

Employer: ____________________ Job description/Title ____________________

Address: ____________________ Dates: From ____________ To ____________
street city state mm/yy mm/yy

Employer: ____________________ Job description/Title ____________________

Address: ____________________ Dates: From ____________ To ____________
street city state mm/yy mm/yy

8. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a radiologic technologist. Attach an additional sheet if necessary. KSBHA will verify your credentials except for any state that does not provide free and current verifications on their official state website. For those states, you may complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held a radiologic technologist license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

I have never been licensed, registered or certified in another state, or jurisdiction. ☐

State/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date

Applicant Name: ____________________
(please print or type)

9. Certificate of Professional School (Post Secondary School)

It is hereby certified that ____________________ attended ____________________ , in ____________________
(applicant's name) (school's name) (city and state)

beginning ______________ with a completion or anticipated completion date of ______________ during which time
(date - mmddyy) (date - mmddyy)

the applicant pursued and completed all requirements for the program of Radiologic Technology according to the standards of accreditation prevailing at the time. It is further certified that the applicant received or will receive the following degree:

____
(specify degree, certificate, letter of certification or other)

____
(signature of President, Registrar, Dean, Director of Course)

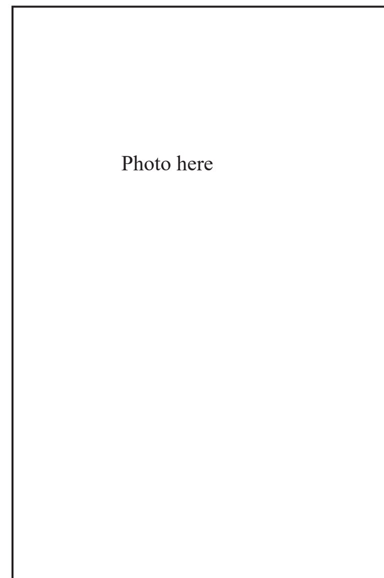
____
date

____
Name of School

School Seal here
(if no school seal, statement must be notarized by the school)

10. Photo.

Attach a **2"x3" wallet size** photograph of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles. or passport photos are **NOT** accepted.



Applicant name: ______________________________
(please print or type)

11. Oath must be signed by applicant and notarized.

I, ____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice as a radiological technologist in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

____
Signature of Applicant

Sworn to before me this ________________ day of

________________________________ 20 _______

SEAL here

________________________________ Notary Public

________________________________ Commission Expires

Application fee of $60, NPDB report fee of $3, and Temporary permit fee $25. Make the fees payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

revised 10/14/15, kl

Applicant Name: ____________________________
(please print or type)

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/ federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes __ No __ If yes:

   Branch:__________________ Dates of Service:__________________ Military ID#:____________________

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes__ No__ If yes:

   Branch:__________________ Dates of Service:__________________ Military ID#:____________________

3. Do you currently reside in Kansas? Yes__ No__ If yes:

   Current Kansas Residence Address:____

4. Do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes __ No __ If yes:

   Intended Kansas Residence Address:____

   Expected Date of Commencing Residence:_____________

If you answered "<u>no</u>" to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. ***This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.*** Yes __ No __If no:

   a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes __ No __

   b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes __ No __ If yes:

Organization that issued private certification/registration:_______________________ Date Issued:__________

*** "Active practice" does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.**

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years?
   Yes __ No __

If you answered "yes" to question #6, you do not need to answer question #7.

7. If you answered "No" to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

[i] An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public. K.S.A. 48-3406(d).

ATTESTATION QUESTIONS

Please answer each of the following questions. **All "yes" answers MUST be thoroughly explained in detail on a separate signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the "yes" box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes___ No___
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes___ No___
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes___ No___
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges? Yes___ No___
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility? Yes___ No___
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private? Yes___ No___
7. Have you ever voluntarily surrendered any professional license? Yes___ No___
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes___ No___
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes___ No___
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes___ No___

11. Has any professional association imposed any disciplinary action against you? Yes___ No___
12. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes___ No___
13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes___ No___
14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes___ No___
15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes___ No___
16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes___ No___
17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes___ No___
18. Have you ever been court martialed or discharged dishonorably from the armed services? Yes___ No___
19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes___ No___
20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company? Yes___ No___
21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes___ No___

It is your continued duty to update the Board on any changes once the application has been submitted.

Third Party Authorization

Must be signed by applicant and notarized.

I,____ , hereby authorize all hospitals, institutions or organization, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

____
Signature of Applicant

SEAL here

Sworn to before me this _____________day of

____________________________ 20 ______

______________________________ Notary Public

____________________________ Commission Expires

revised 1/15/13, kl

LETTER OF COMPLETION

For the purpose of obtaining a temporary license, the Letter of Completion may be submitted 3 weeks prior to graduation or any time after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.

Applicant: Complete the top portion and submit to the school or program.

School or Program: For the purpose of obtaining a temporary license, this form may be completed **3 weeks prior to graduation or any time after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.** Complete the bottom portion and email to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email.

I hereby authorize the school or program listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my education at that institution.

Full Name: ____

Other Names Used (if applicable): ______________________ Date of Birth: __________

Name of School or Program: ______________________________________

Signature: ____________________________________ Date: ______________

TO BE COMPLETED BY THE PRESIDENT, REGISTRAR, DEAN OR DIRECTOR OF COURSE

Name of Applicant: ______________________________________

Name of School or Program: ______________________________________

Address: ____

Start Date: ____________ Completion or Expected Completion Date: ____________

Degree Awarded: ______________________

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named applicant. It is further certified that the applicant completed all requirements according to the standard of accreditations prevailing at the time and will receive the above-stated degree.

______________________________ ______________________
Signature Date

____
Printed Name & Title (Seal)

____
Email

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

LICENSE VERIFICATION FORM

Send to all states or jurisdictions in which you currently, or have ever, held a license, permit, or certification, permanent or temporary. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and email to KSBHA_Licensing@ks.gov or mail it directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of __________________________________ having control of any documents, records, and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; informal, pending, closed or any other pertinent information.

Full Name: ____

Other Names Used (if applicable): ______________________________ Date of Birth: ______________

License or Registration No.: ______________________________________ Issue Date: _____________

Profession: ____

Signature: ____ Date:____________________

Full Name of Licensee or Registrant: ____

License or Registration No.: ______________________________ Status: ____________________

Issue Date: ________________ Expiration Date: ____________

License Method: __________________________ School: _________________________________

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? Yes ___ No ___ Unable to Divulge ___

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? Yes ___ No ___ Unable to Divulge ___

Comments: ____

Signature: ____________________________________ (SEAL)

Title: ____

State Board of: ________________________________

Date: ________________

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

THIRD PARTY RELEASE

If you would like the Kansas State Board of Healing Arts ("Board") staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail it directly to the Board.

I, ____, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: ____________________________________
   Phone: ____________________________________
   Email: ____________________________________
   Relationship: ____________________________________

2. Name: ____________________________________
   Phone: ____________________________________
   Email: ____________________________________
   Relationship: ____________________________________

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

____ ____________________________
Signature of Applicant Date

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

GENERAL INFORMATION AND INSTRUCTIONS

Please visit www.ksbha.org for all statutes and regulations governing Radiologic Technologists.

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. Do not make a commitment to any work dates prior to being licensed.

It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas State Board of Healing Arts (KSBHA).

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A"yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or I did not think the prior act had anything to do with my profession or that it was still on my record or that it was so long ago." There is no excuse for not disclosing.

Kansas application fees must be submitted with the application, are **NOT** refundable, and will be processed upon receipt. The Kansas application fee is $60, NPDB report fee is $3, and temporary permit fee is $25, if applicable. To pay by debit or credit card please complete the credit card authorization form. If paying by check make check payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card.

Temporary Permits are available to those that have graduated but not yet taken the national exam. Temporary Permits are not issued to applicants by endorsement. One (1) temporary permit may be issued by the Board to applicants who meet all the requirement as required under K.S.A. 65-7305 and amendments thereto. Temporary Permits expire 180 days after the date of issue or certification.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" form.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas State Board of Healing Arts. Some forms can be submitted to the Board by fax or as an attachment in an e-mail. Documents not accepted by fax or e-mail: exam certification, certification of school, oath, release, photo, transcripts, and verifications from other states.

Select which organization you have tested and earned certification with. List the number of attempts, date passed, credentials earned, and ID number. Upon initial review of the application the Board will attempt to verify your AART or NMTCB credentials, if the Board is unable to verify your credentials you will be notified. If you have not maintained ARRT certification request a duplicate score report be sent directly to the Board. If you have not yet tested check the corresponding box and the date you are scheduled to test. After testing and earning certification request verification on ARRT letterhead be emailed to KSBHA_Licensing@ks.gov.

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants inlcude a $3 report fee for the Board to obtain the NPDB report.

Licenses/Certificates expire September 30 and are renewed annually. License renewal will be required of all receiving a permanent license prior to June 1.

CHECK LIST - Did you complete the following?

ALL questions answered on the application
Request official & final transcript submitted by the post-secondary school
Request verification from states, countries or jurisdictions, if applicable
Documentation for any "YES" Attestation Questions
Head and shoulder photograph
Fees

Request verification of certification and registration from ARRT or NMTCB, if applicable.
Post-secondary school signature and seal
Notarize and sign Oath
Notarize and sign Release Form

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Please enter required information, sign and date at the bottom. Email or Mail form.

CARD NUMBER

Verification Code
3-4-digit non-embossed number found on the card signature panel

____

Expiration Date
MO YR

_______ / _______

Name (as it appears on the credit card):______________________________

Billing Address:________________ ________________ ________ ________
Street City State Zip

Telephone Number: __________ - __________ - ______________

Payment Amount $________ Purpose of Payment:______________________
(e.g. renewal, application)

Applicant/Licensee Name:____

I agree to pay the above amount per the card issuer agreement.

____
Signature Date

Please Note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.

office use only			

Kansas State Board of Healing Arts
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