

**IOWA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF RADIOLOGICAL HEALTH**

RADIATION THERAPY “PERMIT TO PRACTICE” APPLICATION

Instructions for completing this form:

1. Print or type the required information. Provide the appropriate document(s).
2. Send the completed form and a \$60 initial fee in a check or money order made payable 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; cccraig@idph.state.ia.us

Applicant’s Name: _____ Home Phone Number _____

Home Mailing Address: _____ email address _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____
 High School Graduate GED Certification

Please provide a copy of the ARRT card or proof that you have passed the ARRT certification test or provide your current ARRT Reg. # _____. Current membership in the ARRT is not required. If you are applying for a permit and have not passed the ARRT test, you must pass it before this permit can be issued.

If you have a current, expired, or inactive permit or license in another state, please provide the state and type of license: _____

Have you ever had a permit or license suspended or revoked? no yes. If yes, please state the circumstances.

Current Employer in radiography: _____ Phone number _____

Employer’s Address: _____

City: _____ State: _____ Zip: _____

If you are not currently working in radiography, please provide the name and address of your last radiography employer and the dates of your employment:

Date: _____ Employer: _____

Employer address: _____

Have you:

1. Any medical condition(s) which in any way impair or limit your ability to perform as a radiation therapist? yes no Please specify _____
2. Been engaged in the illegal or improper use of drugs or other chemical substance? yes no
3. Been convicted of a misdemeanor or felony that may impair or limit your ability to perform radiation therapy? Please explain. You must answer "yes" even if the matter has been expunged from the record. yes no
4. Had any disciplinary action brought against you in connection with a certificate or license issued from a certifying or licensing entity? yes no Please explain.
5. Been found guilty of incompetence or negligence during your performance as a radiation therapist? yes no Please explain.

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.

1. I will allow a representative of the Iowa Department of Public Health to comprehensively evaluate whether or not I meet the training standard.
2. The information provided on this form and enclosure(s) is truthful and accurate.
3. My name and address may be sent to companies requesting it for continuing education promotions or employment opportunities

Signature of Applicant
Revised 10/1/2007

Date

Guidelines to continuing education can be found on our website: idph.state.ia.us/eh/permits_to_practice.asp.

Revised 4/2008