

**WEST VIRGINIA MEDICAL IMAGING AND RADIATION
THERAPY TECHNOLOGY BOARD OF EXAMINERS**
P.O. BOX 638
1715 FLAT TOP ROAD
COOL RIDGE, WEST VIRGINIA 25825
TELEPHONE (304)787-4398 TOLL FREE 877-609-9869 FAX (304)787-3030
E-Mail: wvrtboe@suddenlinkmail.com Web Page: www.wvrtboard.org
APPLICATION FOR NUCLEAR MEDICINE OR MRI LICENSURE
(Please Print or Type)

MAKE CHECKS PAYABLE TO WV MI & RTT BOARD

PERSONAL INFORMATION

Name: _____ SS #: _____
(Last) (First) (MI)

Address: _____
(Street or P.O. Box)

(County) (City) (State) (Zip)

Telephone: () _____ Gender: Male: ___ Female: ___ Email: _____

Race/Origin: Caucasian / White ___ Negro/Black ___ Asian ___ Hispanic ___ Other ___

Date of Birth: _____ Place of Birth: _____ Work phone: _____
Month / Day / Year City State

EMPLOYMENT INFORMATION

Employer: Primary: _____ Other: _____

Address: _____

(County) (City) (State) (Zip) (County) (City) (State) (Zip)

Working as R.T. ___ Full Time ___ Part Time ___ Number of Hours per week ___

Setting of Employment: Hospital ___ Private Practice ___ Clinic ___ Other _____

Primary Speciality: Radiographer ___ Therapist ___ Nuclear ___ MRI ___ Ultrasound ___ Other _____
MARK 1 IN YOUR PRIMARY SPECIALITY AND 2 IN YOUR SECONDARY SPECIALITY, IF APPLICABLE.

Not working as an R.T. (Please circle appropriate number)

3. Working in another field
4. Retired
5. Homemaker
6. Other _____

The questions in this section must be answered before a license can be issued.

Do you have a child support obligation? YES ___ NO ___ Are you delinquent? YES ___ NO ___ NA ___
Have you ever been convicted of a felony in the past five (5) years in this or any other state? YES ___ NO ___ Have
you ever been convicted of a misdemeanor in the Radiological Sciences? YES ___ NO ___ (If "yes" to any of the
questions, please give particulars and disposition on a separate sheet).

DECLARATION

I declare that the statements made herein and on accompanying papers have been examined by me and to the best of my knowledge and belief are true and correct. I agree to abide to the Regulations and Rules of the Board. I further understand that a false statement knowingly made by me may be the cause for suspension and revocation of any license issued pursuant to this application and for criminal prosecution and punishment.

DATE

SIGNATURE OF APPLICANT

CONTINUE NEXT PAGE

SECTION I: OBTAINING AN **UNRESTRICTIVE LICENSE** (Complete page 1 and this section) Fee: \$ 100.00

A: Do you have certification from the American Registry of Radiologic Technologists, Nuclear Medicine Technology Certification Board or other? If certification is not in Nuclear Medicine or MRI, you must obtain an Apprentice License (see Section II)

Yes ____ No ____

(If "yes", please provide a copy of the certification. A license will not be issued without this documentation.)

B: Have you ever been issued a license by the Board? Yes ____ No ____

If yes, under what name: _____

C: Have you ever been issued an apprentice license by the Board? Yes ____ No ____

If yes, under what name: _____

SECTION II: OBTAINING AN **APPRENTICE LICENSE** Fee: \$ 100.00

(Complete page 1 and this section)

To obtain an apprentice license, you must have a license issued by the Board and desire to cross-train in the specified discipline. You will have a limited time to obtain certification in the specified discipline.

DO YOU WANT AN APPRENTICE LICENSE? Yes: ____ No: ____

THE LICENSE FEES ARE ON AN ANNUAL BASIS AND THE FEE STRUCTURE IS AS FOLLOWS:

APPLICATION FEE:	\$100.00
RENEWAL FEE:	\$ 65.00
REINSTATEMENT FEE (DELINQUENT)	\$ 25.00
RECIPROCITY FEE	\$ 40.00
DUPLICATE LICENSE	\$ 15.00
CHANGE OF NAME	\$ 15.00

07/01/07