

**WEST VIRGINIA MEDICAL IMAGING AND RADIATION THERAPY  
TECHNOLOGY BOARD OF EXAMINERS**

P.O. BOX 638  
1715 FLAT TOP ROAD  
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**PODIATRY MEDICAL ASSISTANT APPLICATION FOR PERMIT - \$ 100.00**  
(Please Print or Type)

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_  
(Street or P.O. Box)

\_\_\_\_\_  
(County) (City) (State) (Zip)

Telephone: ( ) \_\_\_\_\_ ASPMA CERTIFICATION #: \_\_\_\_\_

COPY OF CERTIFICATE MUST BE ATTACHED

Gender: Male:  Female:  Race/Origin: Caucasian/White  Negro/Black  Asian  Hispanic  Other

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Month / Day / Year City State

**EMPLOYMENT INFORMATION**

Employer: Primary: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(County) (City) (State) (Zip) (County) (City) (State) (Zip)

Working Full Time  Part Time  Number of Hours per week \_\_\_\_\_ Work phone # \_\_\_\_\_

Setting of Employment: Private Practice  Clinic  Other \_\_\_\_\_

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

Do you have a child support obligation? YES  NO  Are you in arrearage? 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 Radiologic 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 further understand that a false statement knowingly made by me may be the cause for suspension and revocation of any permit issued pursuant to this application and for criminal prosecution and punishment.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT