

**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
EMAIL wvrtboe@suddenlinkmail.com Web Page: www.wvrtboard.org

PODIATRY MEDICAL ASSISTANT APPLICATION FOR RENEWAL - \$ 65.00 IF EXPIRED - \$ 90.00
(Please Print or Type)

PERSONAL INFORMATION

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

Address: _____ E-Mail _____
(Street or P.O. Box)

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

Telephone: () _____ ASPMA CERTIFICATION #: _____
COPY OF CERTIFICATE MUST BE ATTACHED

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 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 by all Rules and Regulations of the Board which are applicable to my profession, including the Code of Ethics. 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