MARYLAND BOARD OF PHYSICIANS

P.O. BOX 37217
BALTIMORE, MARYLAND 21297
(410) 764-4777
1-800-492-6836
www.mbp.state.md.us

TTY FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258

APPLICATION FOR LICENSURE OF RADIATION THERAPISTS, RADIOGRAPHERS, OR NUCLEAR MEDICINE TECHNOLOGISTS

If you have been previously certified in Maryland as a radiation therapist, radiographer, or nuclear medicine technologist, DO NOT USE THIS APPLICATION. Download a copy of the reinstatement application from the Board's website at *www.mbp.state.md.us* or call the number listed above and request a reinstatement application.

INSTRUCTIONS AND IMPORTANT INFORMATION

1. **Fee:** The fee for licensure is **$150.00**. Checks and/or money orders should be made payable to the Maryland Board of Physicians. **The application fee is not refundable. (Please note that without the required fee, your application will not be processed.)**

2. **Mailing Instructions:** Mail your completed application, appropriate fee and supporting documentation to the address at the top of this page (P.O. Box 37217, Baltimore, MD 21297). DO NOT mail or hand deliver your application to the Board office. Any application that is mailed or hand delivered to the Board office will be forwarded to the post office box at the top of the application within 24 - 48 hours. This may delay the processing of your application at least a week. **FYI - Federal Express (FEDEX) or UPS does not deliver to post office boxes.**

3. **Processing time:** Generally, the application process takes approximately 2 - 4 weeks. However, the process may take longer depending on the individual applicant's circumstances or if the individual does not provide the required documentation on a timely basis.

Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact if additional documentation is required.

If you have met all the requirements for licensure, your analyst will generally issue a license within 3-5 business days from the receipt of your application. Once the license is issued, you should be able to check it on the Board's website at *www.mbp.state.md.us. The website is updated every 24 hours.*

PRIOR TO CONTACTING YOUR ANALYST, PLEASE CHECK THE BOARD'S WEBSITE TO DETERMINE IF YOU HAVE BEEN ISSUED A LICENSE. Click Search Practitioner Profiles; then enter your last name into the appropriate field.

4. **Application:** Complete all questions on the application. Answer the **Character and Fitness questions** "YES" or "NO." If you answered "YES" to any item, **please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge. Incomplete applications will delay the review process.**

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

5. **Name**: If the name on the application form differs from the name on your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

INSTRUCTIONS AND IMPORTANT INFORMATION (CONTINUED)

6. **Address**: The non-public (home) address will be the location to which the Board directs all correspondence. The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

7. Date of Birth: Health Occupations Article §14-5B-09(b)(2) requires applicants to be at least 18 years old. Date of birth will also be used for identification and a criminal background checks.

8. Race and Sex This information is not a requirement for certification, but the information provided will be used for identification purposes and for criminal background checks only.

9. Social Security Number: Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for their professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

10a. Verification of Education: Complete Part I of the appropriate verification of education form. Send it to the authorized school official and have the official return it to the Board. If your educational program was not accredited by either the Joint Review Committee on Education in Radiologic Technology (JRCERT) or the Joint Review Committee on Educational Programs in Nuclear Medicine Technology (JRCNMT), you will be required to go through an educational equivalency process. To find out if your school was accredited by the JRCERT, check their website at **www.jrcert.org**. To find out if your school was approved by the JRCNMT, check their website at **www.jrcnmt.org.**

10b. Education Equivalency: If you did not graduate from a radiography or radiation therapy program accredited by the JRCERT or graduate from nuclear medicine technology program accredited by the JRCNMT, you must provide documentation that you graduated from an equivalent program which meets the guidelines for education outlined in 42 CFR Part 75, Appendix A (radiography); Appendix D (nuclear medicine technology); or Appendix E (radiation therapy) or documentation indicating comparable on-the-job training you received which meets the guidelines for education outlined in 42 CFR Part 75, *http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr75.3.pdf.*

11. Temporary Licensure: An applicant who meets all requirements for licensure, except for the examination requirement, is eligible for a temporary license provided he/she is scheduled to take the next available national certifying examination within three months after graduation. A temporary license expires 30 days after the date the applicant was scheduled to take the required examination.

A temporary licensee who provides the Board with documentation of passing the ARRT or NMTCB examination will receive full licensure.

12. National Certification: Verification of certification from the the national certifying organization. Contact the certifying organizations and have them send verification of certification to the Board's office at 4201 Patterson, Baltimore, MD 21215. (Please **DO NOT** send applications to this address.). ARRT contact information: **www.arrt.org** or (651) 687-0048. NMTCB contact information: **www.nmtcb.org** or (404) 315-1739.

13. Licensure in Other States: If you are or have ever been certified/registered/licensed to practice radiation therapy, radiography, or nuclear medicine technology, or have ever been certified/registered/licensed to practice ANY other health profession in Maryland or in any other state(s), complete the Part 1 of the **Verification of Other State Licenses form and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form.**

INSTRUCTIONS AND IMPORTANT INFORMATION (CONTINUED)

14. English Competency: **English Language Competency:** Demonstrate verbal and written competency in the English language by:

a. Graduation from an English-speaking high school, undergraduate school, or professional school; **OR**

Provide evidence that you achieve a passing score on both the Test of Spoken English (TSE) and the Test of English as Foreign Language (TOEFL).

b. Achieve a passing score of at least 220 on the TSE **and** at least 550 TOEFL Paper and Pencil examination taken before July 1995; **OR**
c. Achieve a passing score of at least 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam beginning July 1995; **OR**
d. Achieve a passing score of at least 26 on the spoken part **and** 79-80 on the written part of the TOEFL.

To obtain score reports for the the TSE and the TOEFL, contact the Educational Testing Services by phone at 1-877-863-3546 or 609-771-7100; by fax 610-290-8922; or on their website at www.ets.org.
http://www.toefl.org.

15. **Release and Certification:** A recent photograph must be pasted to the release and the form must be signed and dated in the presence of a notary. If you wish the Board to release your information to a third party complete the third party release statement. Sign and date the certification. Your application will not be processed if the Certification is not signed and dated.
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Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, braille, large print, audio tape). If you need such accommodation, please notify the MBP ADA designee, Ellen Douglas Smith at (410)764-2477 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258). If you have a complaint concerning the MBP's compliance with the ADA, please contact Ms. Smith.

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FOR BANK USE ONLY

DATE:______/______/ 200___

CHECK NUMBER:_____________

AMT PAID: $ ________________

NAME CODE:________________

APPID: 1

FOR BOARD USE ONLY

License # ____________________
Date of Licensure ____/____/____
Expiration Date ____/____/___

APPLICATION FOR LICENSURE OF RADIATION THERAPISTS/ RADIOGRAPHERS/NUCLEAR MEDICINE TECHNOLOGISTS

Fee: $150.00

CHOOSE ONLY ONE - Use a separate application for each profession.

TYPE OR PRINT LEGIBLY

_______ Radiographer
_______ Radiation Therapist
_______ Nuclear Medicine Technologist

1. Full Legal Name

____

Last Name and Generational Indicator (Jr., III, etc. First Name Middle Name Maiden Name

2a. Non-Public Address: (This address, usually your home, is for correspondence between you and the Board. However, if no public address is listed, this address will be made available to public.) Do **NOT** use a P.O. Box. **If you change your address prior to being licensed, immediately notify the Board in writing.**

____

Street Name and Number APT

____

City State Zip Code

2b. Public Address: (Your public address of record. This address, usually your office, is available to the public and may be posted on the internet. **If you change your address prior to being licensed, immediately notify the Board in writing.)**

____

Facility Name

____

Street Name and Number

____

City State Zip Code

3a. Telephone - Home: (________)________ - ________

3b. Work: (________)________ - ________

4. E-mail address: ____

5. Social Security No._________-________-___________

6. Date of Birth: _____________-_______________-_____________
MM DD YYYY

7. Sex: _____ Male ____ Female

8. Race: _____ Caucasian _____Hispanic
_____ African American _____ Asian
_____ Native American _____Other

Applicant's Name____________________________________ **Date:** _________________________

9. **EDUCATIONAL PROGRAM**

____ _________/__________/___________

Name of School/Program Graduation Date

____

Street Address

____

City State Zip Code

____

Telephone Number, including area code

10. **CERTIFYING EXAMINATION:** Check the national organization(s) which sponsored the qualifying examination and provide information and documentation for each. Provide exam date.

CHECK ORGANIZATION	DATE OF EXAMINATION	CERTIFICATION NUMBER
American Registry of Radiologic Technologists	_______/_______/_______	______________________
Nuclear Medicine Technology Certification Board	______/_______/_______	______________________

11. **TEMPORARY LICENSURE:** Complete this section only if you have **NEVER** taken and passed the ARRT or the NMTCB examination. If you have already taken the examination, whether you passed or failed, you are not eligible for temporary licensure.

a. For temporary licensure, give the date you are scheduled to take the ARRT exam.

__________/___________/___________ *(Exam must be scheduled within three months after graduation.)*

mm dd yyyy

b. For temporary licensure, give the date you are scheduled to take the NMTCB exam.

__________/___________/___________ *(Exam must be scheduled within three months of graduation.)*

mm dd yyyy

12. **ORAL AND WRITTEN COMPETENCY IN ENGLISH - CHECK ONE**

_____ I graduated from a recognized English-speaking professional school; **OR**

_____ I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment; **OR**

I achieved a passing score of at least:

______ 220 on the TSE **and** at least 550 TOEFL Paper and Pencil examination taken before July 995; **OR**

______ 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam beginning July 1995; **OR**

______ 26 on the spoken part **and** 79-80 on the written part of the TOEFL.

Applicant's Name__________________________________ **Date:** _____________________

13a. **Verification of Licensure as a Radiation Therapist, Radiographer, or Nuclear Medicine Technologist.**: List all states or other jurisdictions in which you hold or have held registration, certification or licensure to practice Radiography, Radiation Therapy, Nuclear Medicine Technology. Please complete and mail the attached **Verification of Other State License(s)** form to the appropriate State Board(s). If you have never been registered, certified, or licensed, **please write N/A below.** (Use additional sheets, if necessary)

STATE	REGISTRATION/LICENSE#	CATEGORY (RRT, R.N., Etc.)	YEAR ISSUED	EXPIRATION DATE

13b. **Verification of Licensure as a health care professional other than a Radiation Therapist, Radiographer, or Nuclear Medicine Technologist.** List all states or other jurisdictions, including Maryland, in which you have ever held a license/certification/registration to practice in ANY other health occupation. Be sure to complete and mail the attached **Verification of Other State License(s)** form to the appropriate State Board(s). If you have never been registered, certified, or licensed, **please write N/A below.** (Use additional sheets, if necessary)

STATE	REGISTRATION/LICENSE#	CATEGORY (RT, NMT., Etc.)	YEAR ISSUED	EXPIRATION DATE

CHARACTER AND FITNESS QUESTIONS

14. Answer **YES"** or **"NO"** to the following items. If you answered **"YES"** to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Examples of documentation is next to the question. Please note that these examples are not all inclusive. ***Failure to provide documentation and a signed and dated explanation will delay the processing of your application.***

______ A. Have you ever been denied a license, certification or registration to practice any health occupation? **(e.g. state board orders and/or charges; adverse or disciplinary actions in any healthcare facility)**

______ B. Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? **(e.g. state board orders and/or charges; adverse or disciplinary actions)**

______ C. Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? **(e.g. state board orders and/or charges; adverse or disciplinary actions)**

______ D. Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? **(e.g. provide name of institution, correspondence received or sent, related documents.)**

______ E. Have you ever been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? **(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**

______ F. Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? **(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**

______ G. Do you currently have a physical or mental condition which may affect your ability to practice your profession? **(e.g. medical evaluations)**

______ H. Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? **(e.g. malpractice claims)**

______ I. Have you ever been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, type of discharge. **(e.g. DD214)**

______ J. Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? **(e.g. copy of charges)**

15. RADIATION THERAPIST/RADIOGRAPHER/NUCLEAR MEDICINE TECHNOLOGIST - Beginning with the most recent, describe your employment history since graduation from high school. Include employment in non-health related professions. Explain any lapsed time over 1 year in which you did not practice in ANY profession. Please copy this page if you need more space.

Length of Employment Month and Year	1) Name of Employer 2) Address of Employer 3) City, State, Zip Code 4) Supervisor	Position Phone Number
From	1)	
	2)	
To	3)	
	4)	
From	1)	
	2)	
To	3)	
	4)	
From	1)	
	2)	
To	3)	
	4)	
From	1)	
	2)	
To	3)	
	4)	

16. RELEASE:

I agree that the Maryland Board of Physicians (the Board) and **Radiation Therapy/Radiography/Nuclear Medicine Technology and Radiologist Assistance Advisory Committee** may request any information necessary to process my application for Radiation Therapist/Radiography/Nuclear Medical Technology in Maryland from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

____
Name in print

____ ____________________________
Signature Date

17. Affix a passport quality photo taken within the last 90 prior to submitting the application.

AFFIX PASSPORT QUALITY PHOTO TAKEN WITHIN 90 DAYS PRIOR TO SUBMITTING THE APPLICATION

Date picture was taken

________ _________ ________
mm dd yyyy

18. (Optional) Third Party Release: (If you plan to use an intermediary to receive information about the status of your application, please complete the release.) I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

____ ______________________
Name of person to whom the information can be released Date

____ ______________________
Phone number if person to whom information can be released Applicant's signature

19. CERTIFICATION: THE FOLLOWING MUST BE SIGNED AND DATED IN THE PRESENCE OF A NOTARY PUBLIC AFTER THE APPLICANT'S PICTURE HAS BEEN ATTACHED ABOVE. ***YOUR APPLICATION WILL NOT BE PROCESSED IF THE CERTIFICATION IS NOT SIGNED AND DATED.***

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 14-5B-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.10 which govern the practice of Radiation Therapy, Radiography, and Nuclear Medical Technology in Maryland.

___________________________________ __________________________
Applicant's Signature Date

20. NOTARY: PLEASE COMPLETE THEN AFFIX NOTARY.

STATE OF ________________________________ CITY/COUNTY OF ________________________

I HEREBY CERTIFY that on this _________ day of ___________, 200_____, before me, ____________________,
(print name of notary)

a Notary Public of the aforesaid State and City/County, personally appeared ______________________, and made oath in
(print name of applicant)

due form of law that signing the foregoing application was his voluntary act and deed.

AS WITNESS my hand and Notarial Seal. _____________________________ My Commission Expires: __________________
Notary Public

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VERIFICATION OF OTHER STATE LICENSES

RADIATION THERAPISTS/RADIOGRAPHERS/NUCLEAR MEDICINE TECHNOLOGISTS INITIAL CERTIFICATION

APPLICANT: Please complete and sign **Part 1** of this form and mail it to each State Board that ever issued you a certification, license or registration to practice Radiation Therapy, Radiography or Nuclear Medical Technology. Also send this form to any State Board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other allied health professional. Contact the state(s) to which you are sending this form to request fee information. Please copy this verification request if you need to send it to more than one state board.

PART 1:

Name of State Board: ______________________________

Location of State Board: ______________________________

Name: ______________________________
(Print) Last Name First Name Middle Name Maiden Name

Date of Birth: ______________________ Social Security Number: ______________________

Certification/license/registration number: ______________________ Date issued: ______________________

Expiration Date: ______________

Professional School of Graduation: ______________________ Year: ______________

Signature: ______________________ Date: ______________________

PART 2: TO BE COMPLETED BY STATE BOARD: Authorized Official: Please certify the following information for the above individual and send this form directly to the Maryland Board of Physicians at the above address.

Certification/license/registration number: ______________ Date issued: __________ Expiration Date: ______________

Is license/certification/registration in good standing? ______________ Not in good standing? ______________

If not in good standing was it: revoked _______ suspended _______ surrendered _______ reprimanded __________

Other Derogatory Information or Pending Charges: ______________________________

____

Printed Name of Authorized Official: ______________________ Title: ______________________

Signature of Authorized Official: ______________________ Date: ______________________

Telephone Number, including area code: ______________________________

Board Seal

10/2008

For Board Use Only

Program accredited? ____ ____
Y N

Date verified ___________

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VERIFICATION OF PROFESSIONAL EDUCATION
NUCLEAR MEDICINE TECHNOLOGISTS

APPLICANT: Please complete **Part 1** and send to the school/program from which you graduated as a nuclear medicine technologist. **Print or type all information.**

PART 1:

NAME: ____
LAST FIRST MIDDLE MAIDEN NAME

SOCIAL SECURITY NUMBER________-__________-________ DATE OF BIRTH _______/_______/_________

PROFESSIONAL SCHOOL OF GRADUATION ____

INCLUSIVE DATES OF ATTENDANCE FROM: ________________TO ___________
MM/YYYY MM/YYYY

DATE OF GRADUATION _____________________________ DEGREE RECEIVED ________________

SIGNATURE OF APPLICANT__________________________________ DATE _____________________

****

TO BE COMPLETED BY REGISTRARS OFFICE: Registrar, Dean or Authorized Official: Please complete **Part 2** and mail the entire form directly to the Maryland Board of Physicians at the above address.

PART 2:

I hereby certify that the above-named individual graduated from this school/program on: _________________.
Date of Graduation

The individual received a __________________________ in _____________________________________. The inclusive
Type: Certificate, AS, AA,BS, BA, etc. Educational Program

dates of attendance were ___________ to ____________. The program was accredited by _______________________
MM/YYYY MM/YYYY Name of accreditor, e.g. JRCNMT

____
NAME OF SCHOOL PROGRAM

____
NAME OF SCHOOL OFFICIAL (PRINT)

____ DATE ___/______________/________
SIGNATURE OF SCHOOL OFFICIAL

______________________________ ______________________________
TITLE OF SCHOOL OFFICIAL TELEPHONE NUMBER INCLUDING AREA CODE

SEAL OF THE EDUCATIONAL INSTITUTE

For Board Use Only

Program accredited? ____ ____
Y N

Date verified ___________

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VERIFICATION OF PROFESSIONAL EDUCATION FOR RADIOGRAPHERS OR RADIATION THERAPISTS

APPLICANT: Please complete **Part 1** and send this form to the school/program from which you graduated from a Radiation Therapy or Radiography educational program. **Print or type all information.**

PART 1:

NAME: ____
LAST FIRST MIDDLE MAIDEN NAME

SOCIAL SECURITY NUMBER________-__________-________ DATE OF BIRTH _______/_______/_________

PROFESSIONAL SCHOOL OF GRADUATION ____

INCLUSIVE DATES OF ATTENDANCE FROM: ________________TO ___________
MM/YYYY MM/YYYY

DATE OF GRADUATION _____________________________ DEGREE RECEIVED ________________

SIGNATURE OF APPLICANT__________________________________ DATE _____________________

****

TO BE COMPLETED BY REGISTRARS OFFICE: Registrar, Dean or Authorized Official: Please complete **Part 2** and mail the entire form directly to the Maryland Board of Physicians at the above address.

PART 2: I hereby certify that the above-named individual graduated from this school/program on: _________________.
Date of Graduation

The individual received a __________________________ in _____________________________________. The inclusive
Type: Certificate, AS, AA,BS, BA, etc. Educational Program

dates of attendance were ___________ to ____________. The program was accredited by ______________________
MM/YYYY MM/YYYY Name of accreditor, e.g. JRCERT

____
NAME OF SCHOOL PROGRAM

____
NAME OF SCHOOL OFFICIAL (PRINT)

____ DATE ______/___________/________
SIGNATURE OF SCHOOL OFFICIAL

________________________________ ________________________________
TITLE OF SCHOOL OFFICIAL TELEPHONE NUMBER INCLUDING AREA CODE

SEAL OF THE EDUCATIONAL INSTITUTE