NMT2
Verification of Practice Experience Supplemental Form

Maryland Board of Physicians
Allied Health Unit
P.O. Box 2571
Baltimore, Maryland 21215
Telephone: 410-764-4777 or 800-492-6836
E-mail: mbpmail@rcn.com

Application for Licensure: Nuclear Medicine Technologist
Verification of Full-time Practice Experience as a Nuclear Medicine Technologist

General Instructions and Important Information

Complete the form only if you meet the following education qualifications:

- Did not graduate from a Joint Review Committee on Educational Programs in Nuclear Medicine Technology (JRCNMT)-accredited Nuclear Medicine Technology program;
- Graduated from a Nuclear Medicine Technology program that is recognized by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board;
- Possess a current, active, unrestricted license as a Nuclear Medicine Technologist in another state or are otherwise recognized as a Nuclear Medicine Technologist in another state;
- Have at least three (3) years of full-time practice experience as a Nuclear Medicine Technologist in another state. The minimum of three (3) years of practice experience must have occurred within the last five (5) years immediately preceding the submission of the application; and
- Have no history of public disciplinary action taken, or pending, against any license currently or previously held or expired.

An Applicant who meets the above qualifications must have an employer, supervisor or colleague verify, on the attached form **NMT3**, that the Applicant has satisfactorily practiced Nuclear Medicine Technology on a full-time basis for at least three (3) of the last five (5) years immediately preceding the submission of application.

►Instructions for the Applicant:

1. Complete Part 1.
2. Send the form to an employer, supervisor or colleague. Have the employer, supervisor or colleague complete Part 2 and return the form directly to the Board of Physicians. **The Board will not accept the form from the Applicant.**

NOTE: You may send copies of the form with Part 1 completed to all individuals necessary to verify that you have a minimum of three (3) years of full-time practice as a Nuclear Medicine Technologist in another state. A minimum of three (3) years of the practice experience must have occurred within the last five (5) years immediately preceding the submission of the application.

►Instructions for Completion of Part 2:

Part 2 must be completed by the employer, supervisor or colleague with personal knowledge of the Applicant's full-time practice as a Nuclear Medicine Technologist.

The employer, supervisor or colleague completing Part 2 must send the form directly to:

Maryland Board of Physicians
Allied Health Unit
P.O. Box 2571
Baltimore, Maryland 21215

***** Do not return the form to the Applicant. *****

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Verification of Practice Experience Supplemental Form

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571, ATTN: Allied Health Unit
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836

VERIFICATION OF FULL-TIME PRACTICE EXPERIENCE AS A NUCLEAR MEDICINE TECHNOLOGIST

Verification of at least three (3) years of satisfactory, full-time practice experience as a Nuclear Medicine Technologist in another state is required for applicants who have not graduated from a JRCNMT-accredited Nuclear Medicine Technology program. The minimum of three (3) years of full-time Nuclear Medicine Technologist experience must have occurred within the last five (5) years immediately preceding the submission of the application.

Part 1 Applicant: Complete Part 1 only and send to your employer, supervisor or colleague for verification.

Name: _____
Last Name and Generational Indicator (Jr, III, etc.) First Name Middle Name Former Name

Address: _____
Street Address City State Zip Code

Telephone Number: _____ **Email Address:** _____

Applicant's Signature: _____ **Date:** _____

Part 2 Employer, supervisor or colleague: Verify the practice experience of the Applicant named above.

***** When Part 2 is completed, mail this form to the Board of Physicians' address noted at the top of this page. *****

1. In what capacity did you or do you work with the above-named Applicant? Please check all that apply.

☐ Employer ☐ Supervisor ☐ Colleague

2. Dates you have worked with the Applicant: From: _____ **to** _____

3. Was the Applicant's practice experience full-time? ◯ Yes ◯ No

4. Dates the Applicant worked full-time *(if different than dates in Item 2)*: From _____ **to** _____

5. Name of practice site: _____

6. Address of practice site: _____

7. Was the work the Applicant performed as a Nuclear Medicine Technologist satisfactory? ◯ Yes ◯ No

8. Additional comments:

_____

_____

_____

_____ _____
Printed Name Signature

_____ _____
Title Date

_____ _____
Telephone Number E-mail address