

VERIFICATION OF OTHER STATE LICENSE FOR A RADIATION THERAPIST LICENSE

**Part 1** **APPLICANT:** Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license to practice as a Radiation Therapist. Also send use this form to send to each state board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: \_\_\_\_\_

State of Licensure: \_\_\_\_\_ License Number: \_\_\_\_\_

Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 (Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Professional School of Graduation: \_\_\_\_\_ Year: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2** **AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD:** Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

License Number \_\_\_\_\_ Date Issued \_\_\_\_\_ Expiration Date \_\_\_\_\_

Is/was the license in good standing? Yes No

If not in good standing is/was it:  reprimanded  suspended  revoked  surrendered

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? Yes No

If yes, please explain: \_\_\_\_\_

Other Derogatory Information or Pending Charges: \_\_\_\_\_

\_\_\_\_\_  
 Printed Name of Authorized Official

\_\_\_\_\_  
 Title of Authorized Official

\_\_\_\_\_  
 Signature of Authorized Official

\_\_\_\_\_  
 Direct Telephone Number

\_\_\_\_\_  
 Printed Name of State

\_\_\_\_\_  
 Date

