Clear Form

Radiation Control Program

Radiation Therapy or Radiologic Imaging
Registration form for persons working without credentials on or before 01/01/2020

A person who performs Radiation Therapy or Radiologic Imaging as part of his or her employment on or before January 1, 2020 may continue to perform any such activity on and after that date without complying with the requirements of NRS 653.500 and NRS 653.520 as applicable, pursuant to SB 130 Sec.75 if he or she:

a) Submits this form to Register or Renew Registration with the Division.
b) Submits to the Division a signed "Attestation of Employee Training" form as proof of training in radiation safety and proper positioning for X-ray photographs provided by the holder of a license.
c) Submits to the Division documentation showing adequate instruction in the safe operating procedures and competency in the safe use of the X-ray system pursuant to NAC 459.552(4) as applicable.
d) Submits to the Division a signed "Attestation" form confirming knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.
If needed Safe Injection Training is linked here:
https://nvophieonlinetrainings.articulate-online.com/ContentRegistration.aspx?DocumentID=6be65da9-bd5c-4f9c-b6ef-1c8e9dd4a8de&Cust=77069&ReturnUrl=/p/7706940194
e) If renewing registration, submits proof of completing the required continuing education credits relating to category A or A+, by an approved National Professional Organization.
f) Provides any information requested by the Division.
g) Does not expand the scope of his or her duties relating to Radiation Therapy or Radiologic Imaging, as applicable.
h) Submit this application and any required documentation to *DPBH, Radiation Control Program* 675 Fairview Dr., Ste. 218 Carson City, Nevada 89701.

Upon approval of your application, you will be invoiced in the amount of $200 and issued a License or Limited License as applicable. This registration expires 2 years after the date on which it was issued and must be renewed on or before that date.

Employed in modality on or before 01/01/2020? (Check one): ☐ Yes ☐ No

Please Select the appropriate Scope of Practice that this application is for:

Limited License:
☐ Chest ☐ Extremity ☐ Spine ☐ Skull / Sinus ☐ Foot /Ankle
☐ Bone Densitometry

License:
☐ Radiation Therapy ☐ Nuclear Medicine ☐ Radiologists Assistant
☐ Radiology

Nevada State Division of Public and Behavioral Health
675 Fairview Dr., Ste 218 – Carson City, Nevada 89701
Tel: (775) 687-7550 – *Fax*: (775) 687-7552

Revised 11/2019

Applicant's last Name First name MI. SSN:[1]

Street Address City State Zip Code

Name of Employer during that time.

Employer's Address City State Zip Code

Phone Number Fax Number Email Address

[1] Required pursuant to NRS 653.550(1)(a).

	PERSONAL DATA	Y	N
1.	Within the past 10 years, were you suspended from work, been restricted in job duties, or denied by state, federal or foreign jurisdiction from performing your job?	☐	☐
2.	Within the past 10 years, were you disciplined for unprofessional conduct such as patient abuse, incompetence, negligence, or unsafe practices?	☐	☐
3.	Within the past 10 years, were you convicted of a felony, or named in any past or pending civil suit alleging incompetence or negligence in the care of others?	☐	☐
4.	Are you presently afflicted by any medical condition which may impair your ability to practice with reasonable skill and safety?	☐	☐

If **YES** to any of questions 1 through 4, submit an explanation with this application. [2]

[2] A Yes answer does not necessarily preclude licensure.

CHILD SUPPORT INFORMATION [3]

☐ I am **NOT** subject to a court order for the support of a child.

☐ I am subject to a court order for the support of one or more children and am in compliance with the order, or am in compliance with a plan approved by the district attorney (or other public agency enforcing the order for the repayment of the amount owed pursuant to the order); or

☐ I am subject to a court order for the support of one or more children and am **NOT** in compliance with the order or plan approved by the district attorney (or other public agency enforcing the order for the repayment of the amount owed pursuant to the order).

[3] This application cannot be processed until the applicant checks the appropriate box.

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ATTESTATION

I,_____, attest that I am the person described and identified in this application; that I have answered all questions in this application truthfully and completely; that any furnished supporting documentation is accurate to the best of my knowledge. I understand that prior to making a determination regarding my application, the Division may require additional information from me.

Signature: _____ Date: _____