

Radiation Control Program Rural Authorization Application



Please Choose the appropriate scope that this application is for:

(check all that apply)

Full Authorization: RRA Radiation Therapy Radiology Nuclear Medicine

Limited Authorization: Chest Extremity Spine Skull/Sinus Foot/Ankle

Bone Densitometry Fluoroscopy CT

ADDITIONAL ACT NAME	FIDCT NAME		MIDDLE INITIAL
APPLICANT'S LAST NAME	FIRST NAME		MIDDLE INITIAL
	NAME ON CREDENTIAL ¹		
CTDEET ADDDECC	CITY	CTATE	710.000
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER		E-MAIL ADDRESS
NAME OF CURRENT EMPLOYER	EMPLOYER'S ADDRESS		PHONE NUMBER

- Submit proof of training in radiation safety and proper positioning and a signed attestation.²
- Submit nonrefundable check payable to Radiation Control Program in the amount of \$50.00.

	PERSONAL DATA		N
1.	Within the past 10 years, was your certificate or license suspended, revoked, restricted, or denied in any state, federal or foreign jurisdiction?		
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. ³

¹ If different, submit copy of marriage license, court decree, etc.

² Include proof of:

⁽a) Signed attestation as approved by the Division

³A YES answer does not necessarily preclude licensure

CHILD SUPPORT INFORMATION 4 ☐ 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 \Box 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). ⁴ This application cannot be processed until the applicant checks the appropriate box. ATTESTATION , 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 the 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