



Radiation Control Program Registration Application



Computed Tomography or Fluoroscopy
registration form for persons working without
credentials on or before 01/01/2020

New Renewal Update

A person who performs Computed Tomography or Fluoroscopy as part of his or her employment on and before January 1, 2020 may continue to perform any such activity on and after that date without complying with the requirements of NRS 653.630 or NRS 653.640 as applicable, pursuant to NRS 653.620(3) 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. This attestation is not required for a renewal.
- (c) Submits to the Division a signed "Attestation of Safe Injection Training" form confirming knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention.

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>

- (d) Provides any information requested by the Division.
- (e) Does not expand the scope of his or her duties relating to computed tomography or fluoroscopy, as applicable.
- (f) Submit this application, please include \$200 application fee (Check or Money Order) and any required documentation to the Radiation Control Program, Division of Public and Behavioral Health 675 Fairview Dr., Ste 218 Carson City, Nevada 89701.

Upon approval of your application, you will be issued a Registration Certificate. 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 and before 01/01/2020? (Check one): Yes No

Please select the appropriate scope of practice that this application is for:

Computed Tomography Fluoroscopy

Applicant's Last Name First Name MI. SSN or APIN:¹

Street Address City State Zip Code

Phone Number Email Address

Name of Employer during that time.

Employer's Address City State Zip Code

Phone Number

Fax Number

Email Address

¹ Required pursuant to NRS 622.238(3) and 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Within the past 10 years, were you disciplined for unprofessional conduct such as patient abuse, incompetence, negligence, or unsafe practices? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Are you presently afflicted by any medical condition which may impair your ability to practice with reasonable skill and safety? | <input type="checkbox"/> | <input type="checkbox"/> |

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 INFORMATION³

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.

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: _____