Clear Form

Radiation Control Program
Registration Application

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

☐ New ☐ Renewal ☐ Update

A person who performs Radiation Therapy or Radiologic Imaging 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 653.500 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. 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.
For access to the Safe Injection Training, please contact Kimisha Causey at kcausey@health.nv.gov , if needed.
d) If renewing registration, submits proof of completing 24 continuing education credits for a license, or 20 continuing education credits for a limited license relating to category A or A+, by an approved National Professional Organization.
e) Provides any information requested by the Division.
f) Does not expand the scope of his or her duties relating to Radiation Therapy or Radiologic Imaging, as applicable.
g) 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 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

_____
Applicant's Last Name First Name MI. ☐SSN or ☐APIN:[1]

_____
Street Address City State Zip Code

_____
Phone Number Personal Email Address

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

_____

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?	☐	☐
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.

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: _____

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