Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Cody Phinney, MPH
Administrator

Ihsan Azzam, Ph.D,.M.D.
Chief Medical Officer

Attestation of Employee Training

This attestation applies to persons engaged in Radiation Therapy, Radiologic Imaging, Computed Tomography or Fluoroscopy as part of his or her employment on January 1, 2020, pursuant to Nevada Administrative Codes, (NAC) 653.105. **This application form is intended for Nevadans and out-of-state practitioners, actively practicing on or before January 1, 2020, to be grandfathered in, while our laws changed. It is a limited hold over to prevent those actively practicing from having to cease work. It is not intended to be a permanent holdover to allow those with inactive, suspended, or retired licenses or registrations to return to practice after some gap in practice.** He or she must:

- **Submit this attestation to the Division as proof of completed training in radiation safety and proper positioning for X-ray photographs.**
- **Select the modality below and describe, in detail, your scope of practice or duties engaged in before or on January 1, 2020. Applicant cannot expand scope of practice or duties as of 1-1-2020.**

Did you practice in the modality on or before January 1, 2020? (Must respond):

Please select the appropriate modality engaged in on 1/1/2020 below: YES: ☐ NO: ☐

Applying for a License-Grandfathered:

Radiologic Technology ☐ Radiation Therapy ☐

Applying for Registration Certificate:

Computed Tomography (CT) ☐ Fluoroscopy ☐

Applying for a Limited License-Grandfathered:

Chest ☐ Extremity ☐ Spine ☐ Skull/Sinus ☐ Foot/Ankle ☐ Bone Densitometry ☐

Describe, in detail, to your knowledge, training, and experience of your selection above to your scope of duties (scope of practice, as applicable). Please include types of procedures and approximately how many cases you were involved in prior to January 1, 2020. You may use additional supporting documentation.

Employment dates	Employer contact information	Description of modalities from above

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675 Fairview Drive, Suite 218 ● Carson City, NV 89701 ● (775) 687-7550 ● Fax (775) 687-7552 ●
radiationcontrolprogram@health.nv.gov ● dpbh.nv.gov/Reg/Radiation_Control_Programs/

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: _____

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

Street Address	City	State	Zip Code

Current Employer, if applicable

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).

⇨ *This section below must be completed by either a Physician, licensed Physician's Assistant (PA-C) or licensed Radiologic Technologist who has personally worked with the applicant.*
The signee below must hold a license issued by the Division for the modality indicated, or hold appropriate credentials, or have direct experience to verify the applicant's scope of practice or duties. Submit a copy of any documentation or information used to verify the training of the applicant. Submit a copy of your license, any credentials, or describe your direct experience based on the modality verified.

☐ **I attest the applicant listed was employed and performing radiation therapy or radiologic imaging the modalities indicated above as part of his or her employment on or before January 1, 2020.**

☐ **I attest the applicant has completed training in radiation safety and proper positioning for X-Ray photographs, pursuant to NRS 653.620 (1)(b), in the modalities indicated above.**

I have the following license or registration (mark one):

Physician: ☐ **Physician's Assistant:** ☐ **Radiologic Technologist:** ☐

Attestor's Name:_____Title: _____
(Printed)

Attestor's Signature_____Date: _____

Attestor's License number:_____

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