Radiation Control Program
Registration Application
Rural Authorization
Registration Form

A person who does not hold a license or limited license may take X-ray photographs under the supervision of a physician or physician assistant as part of his or her employment or service as an independent contractor in a rural health clinic or federally-qualified health center pursuant to NRS 653.620 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 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).
(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.
(e) If renewing registration, submits proof of completing 20 continuing education credits relating to category A or A+, by an approved National Professional Organization.
(f) Submit this application, please include $50 application fee (Check or Money Order) and any required documentation to *DPBH, Radiation Control Program* 675 Fairview Dr., Ste. 218 Carson City, Nevada 89701.

Please select the appropriate scope of practice that this application is for: (check all that apply)

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

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

Street Address | City | State | Zip Code

Phone Number | Email Address

Name of Employer

Employer's Address | City | State | Zip Code

Phone Number | Fax Number | Email Address

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

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

Select below the facility type where employed, and if the facility has established a quality assurance program as indicated. If working at more than one location, list each employer separately and attach.

☐ Federally-qualified health center. Pursuant to 42 U.S.C. § 1396d(l)(2)(B).

☐ Rural health clinic. Pursuant to 42 U.S.C. § 1395x(aa)(2).
Upon approval of your application, you will be issued a Rural Authorization registration certificate. This registration expires 2 years after the date on which it was issued and must be renewed on or before that date.

	PERSONAL DATA	**Y**	**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. [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: _____