2216-001 $ 25.00
2216-001 $ 25.00
2216-006 $ 10.00

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATIONS
DIVISION OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

(615) 532-5088 or 1-800-778-4123 ext 25088
www.state.tn.us/health

APPLICATION FOR CERTIFICATION AS AN X-RAY OPERATOR IN A PODIATRIST'S OFFICE

INSTRUCTIONS

1. Complete this application, have it notarized and mail it to the above address.
2. Enclose a non-refundable check for $ 60.00, payable to the Board of Podiatric Medical Examiners.
3. Attach a recent photograph to the front of this application.
4. Enclose proof of being at least eighteen (18) years of age.
5. Enclose proof of graduation from high school or its equivalent.
6. Enclose, or have submitted official verification of successful completion of (60) hours of supervised clinical experience in radiographic methodology, technique, patient care and positioning, equipment maintenance, radiation protection and x-ray quality control.
7. Enclose, or have submitted an official verification of attendance and successful completion of six (6) contact hours of didactic classroom instruction in the field of x-ray operation. (See rules for sponsoring provider.
8. If you are certified in another state(s) as an x-ray operator and or any other health professional, do not complete page 4, instead enclose a copy of the statutes and rules governing your practice in that state. Submit a current verification of active licensure/certification from the other state your residing in.
9. Examination Requirement – In order to be certified pursuant to this Chapter, the applicant must successfully complete an examination approved by the Board and shall achieve a minimum score of 70. **Note; Examination scores obtained by an applicant in order to apply for certification shall be effective for five (5) years from the date that the applicant took the examination or the last part of the examination, should the examination be given in multiple parts.**
10. For criminal background instructions click here.
11. All applicants must complete the attached Declaration of Citizenship form.

Name _____
(First) (Middle and/or Maiden) (Last)

Date of Birth _____ Social Security # _____
(Month) (Day) (Year)

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

U.S. CITIZEN: Yes_____ No_____
All applicants <u>must</u> complete the attached Declaration of Citizenship form

Current Mailing Address

_____
_____
_____

Current Practice Address

_____
_____
_____

Home Phone ( )_____

Work Phone ( )_____

E-Mail Address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? ____ Yes ____ No

List all states where you currently have, or have ever had a health professional license or certification.

_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application***.

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession** is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical diagnoses (if necessary) and exercise reasoned judgments and to learn and keep abreast of professional developments; and
   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform tasks required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

2. Do you currently use chemical substances?		
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety? Please list the substances used_____ _____	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
if yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____

QUESTIONS:	YES	NO
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have held or applied for a license or certificate to practice as an x-ray operator in any state, country or province, has or was it ever been denied, reprimand, suspended, restricted, revoked, or otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a professional society?	_____	_____
9. In relation to the performance of your professional services in any profession:	_____	_____
a. Have you ever had final judgment rendered against you; or	_____	_____
b. Have you ever had settlement of any legal action rendered against you; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
10. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photo, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them when practicing as an x-ray operator in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as an x-ray operator.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications.

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me, this _____ day of _____, 20____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission Expires _____

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Podiatrist's Statement of Clinical Experience

This form must be completed and signed by the supervising podiatrist. This form must be mailed separately from the application and sent to the above address.

Name of Applicant:_____

Social Security Number:_____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

I hereby certify that the above named x-ray operator has obtained sixty (60) hours of clinical training as required in Rule 1155-3-.02(2)(a). Please indicate the number of supervised hours in each of the qualifications that apply.

_____ training in radiographic methodology
_____ technique
_____ patient care and positioning
_____ equipment maintenance
_____ radiation protection
_____ x-ray quality control
_____ other (please describe)_____
_____

Please make a brief statement regarding the professional competence of this applicant:_____
_____
_____

_____ _____
Podiatrist's Name (Please Print) License Number

_____ _____
Podiatrist's Signature Date

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CLEARANCE FROM OTHER STATE LICENSURE/CERTIFICATION

Please complete the top portion of this form and forward it to the regulatory board in each state where you hold or have ever held a license to practice as an health professional. (If additional forms are required this form may be duplicated.) **NOTE:** Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state(s).

****

I was granted _____on _____ by the State of _____
License# Date

The Tennessee Board of Podiatric Medical Examiners requests that I submit evidence that my certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Podiatric Medical Examiners.

Date:_____ Signature:_____

SSN#:_____ Printed Name:_____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

**********'

THIS PORTION IS TO BE COMPLETED BY STATE REGULATORY BOARD

License Number:_____ Date Issued:_____

Basis of Issuance: Endorsement/Reciprocity With:_____
Written Examination:_____
(Provide Description of Exam)

Is the License currently registered: ____ Yes ____ No

Derogatory Information on File: ____ Yes ____ No
If "yes" please attach explanation.

_____ _____ _____
Authorized Signature Title Date

STATE OF TENNESSEE
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NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every* *adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ _____.
Healthcare Profession (Please Print) **License number if applicable**

Please Print Legibly

Name: _____
Last First Middle Maiden
Mailing Address: _____

Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)_____-_____

I am a United States Citizen: ____Yes ____No

Applicants Claiming United States Citizenship **MUST** provide one of the following:

1. Tennessee Driver's License, or photo ID issued by Department of Homeland Security.
2. A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Homeland Security criteria.
3. An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
4. A federally issued birth certificate.
5. A valid, unexpired U.S. passport.
6. A report of birth abroad of a U.S. citizen.
7. A certificate of citizenship.
8. A certificate of naturalization.
9. A U.S. citizen ID card.
10. Any successor document to #'s 4-9 above.
11. SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

If you checked "No" please indicate from the list below which category applies to you:

_____ Permanent Residents

_____ A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

_____ Foreign nationals not present in the United States seeking the issuance or renewal of a professional license.

_____ Asylees who meet the qualifications set out in 8 U.S.C. 1158

_____ Refugees who meet the qualifications set out in 8 U.S.C. 1157

_____ Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.

_____ Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980

_____ Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.

_____ An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status**, please submit one or more of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status:

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.