STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tn.gov/health

TENNESSEE BOARD OF RADIOLOGIC IMAGING and RADIATION THERAPY
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR A LICENSE AS A LIMITED RADIOLOGIC IMAGING PROFESSIONAL

Provided below is a checklist for your personal use and convenience containing all items that must be completed before your application for a Tennessee radiologic imaging professional limited license will be considered.

ALL APPLICATION FEES ARE NON-REFUNDABLE

1. Complete and mail application pages 1 through 6. _____
2. Clearance from other state licensing Boards (Required only if licensed in other states). _____
3. Attach to the application and submit a check or money order in U.S. funds in the amount of $110.00, payable to the State of Tennessee ($100.00 application fee plus $10.00 State Regulatory Fee) _____
4. Applicants for initial licensure must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions _____
5. Submit a copy of a valid, current, government issued photo ID. _____
6. Proof of United States citizenship or evidence of being legally entitled to live or work in the United States (e.g. copy of birth certificate, current passport or see Declaration of Citizenship for qualified alien status) _____
7. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the required documents. The Declaration of Citizenship is available online at: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41832.pdf _____
8. Verification of attendance and successful completion of a Board-approved training course. _____
9. Physician's Statement of Clinical Experience. Complete attachment 1 (This form must be completed by a licensed medical doctor and bear original signature.) _____

10. Verification of passing test scores on the A.R.R.T. Limited Scope Exam _____

11. Copy of high school diploma, GED certificate or official high school transcript sent directly from the educational institution. _____

UNDERSTANDING THE APPLICATION PROCESS

1. All application fees are non-refundable. Accordingly, please familiarize yourself with the laws, rules and requirements for licensure prior to submitting your application.

2. All documents and fees required from you or which must be requested from the appropriate institutions in the application process may be mailed directly to:

   Tennessee Board of Radiologic Imaging and Radiation Therapy
   665 Mainstream Drive
   Nashville, TN 37243 (37228 for courier service only)

3. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board's Administrative Office asks that you please give the Board office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you via US mail. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. Files not completed within ninety (90) days will be closed.

5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is complete, your file will be reviewed and an initial licensure determination made. You will be notified by letter of the initial determination. Application approval may also be accessed through our webpage at www.tn.gov/health, click on licensure verification.

6. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.

7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

8. It is strongly recommended that you do not make arrangements to accept employment in Radiologic Imaging in Tennessee until you are granted a license number by the Board.

9. All documents provided to this office in conjunction with your request for a Radiologic Imaging license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to process your application in an efficient manner.

FOR OFFICIAL USE ONLY

5201-001 $100.00
5201-006 $ 10.00

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APPLICATION FOR A LIMITED LICENSE AS A RADIOLOGIC IMAGING PROFESSIONAL

Select ALL areas for which you completed a board-approved training course:

_____ **Chest** _____ **Extremities** _____ **Skull and Sinus** _____ **Spine** _____ **Bone Densitometry**

PERSONAL INFORMATION

Applicant Name: _____
(*First*) (*Middle*) (*Maiden*) (*Last*)

Have you been known by any other name? Y N If yes, list names: _____

_____

Date of Birth: Mo. _____ Day _____ Yr. _____ Social Security Number: _____ - _____ - _____

Current Home Mailing Address:
_____
_____
_____

Current Practice Address:
_____
_____
_____

Home Phone: _____ Work Phone: _____

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Are you entitled to Live or Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y N (If yes, please provide proof of same.)

Email address:_____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

LICENSURE INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed as a Radiologic Imaging or Radiation Therapy Professional. Additional pages may be added if necessary. A primary source verification can be obtained online or sent directly from each entity. Contact the Licensing Board in each state, country, or province for instructions on obtaining a license verification.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below ALL states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Radiologic Imaging or Radiation Therapy Professional. Additional pages may be added if necessary. A primary source verification can be obtained online or sent directly from each entity. Contact the Licensing Board in each state, country, or province for instructions on obtaining a license verification.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for your attendance in high school. Use the back of this page if you need additional space.

From:_____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution/High School Location

Please complete your employment history for the last 5 years starting with the most current position first. You may use a separate sheet of paper if you need additional space.

DATES		**LOCATION**		**POSITION AND DUTIES**
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	
From: MM/YY	To: MM/YY	(City)	(State)	

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, 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 diagnosis (if necessary), exercise reasoned judgments, and to learn and keep abreast of developments in your profession;

   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 and procedures 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. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. **"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.

5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of the 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.

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 medication) 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.]

COMPETENCY INFORMATION
CONTINUED

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation. Affirmative response requires final documents or orders from the issuing states, courts, and/or agencies.		**YES**	**NO**
2.	Do you currently use chemical substances as defined on page 4?	_____	_____
	If yes, do they in any way impair your ability to practice your profession with reasonable skill and safety?	_____	_____
	Please list: _____		
3.	Have you been diagnosed with a substance use disorder?	_____	_____
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program?	_____	_____
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
6.	If you have ever held or applied for a license or certificate to practice as a Radiologic Imaging or Radiation Therapy Professional in any state, country, or province, has it been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7.	Have you ever had staff privileges at any hospital or health care facility that were revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
8.	Have you ever been convicted (including nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
9.	Have you ever been rejected or censured by a professional society?	_____	_____
10.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	_____	_____
	b. Have you ever entered into any settlement of any legal action; or	_____	_____
	c. Are there any legal actions pending against you or to which you are a party?	_____	_____
11.	Have you ever held a license or certificate in any health care profession that has been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
12.	Have you ever failed an examination? If yes, how many times? _____	_____	_____

AFFIDAVIT AND RELEASE

I, _____, of _____
(*Applicant's Name)* *(City)* *(State)*

being duly sworn and identified as the person referred to in this application 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 in the practice in Radiologic Imaging.

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 medicine.

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/or 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/or other qualifications for licensure.

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

AUTHORIZE release, use and disclosure of otherwise HIPAA-protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

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**

ATTACHMENT 1

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Physician's Statement of Clinical Experience

This form must be completed and signed by the supervising physician. This form must bear the original signature of the supervising physician.

Name of Applicant: _____

Social Security Number: _____

I hereby certify that the above named Limited Scope Operator has obtained clinical training as required in rules and regulations (0880-15.08(2)(c)). Please indicate the number of procedures in each of the qualifications that apply.

# of Hours	Qualifications
_____	Chest (30 hours required)
_____	Extremities (80 hours required)
_____	Skull and Sinus (30 hours required)
_____	Spine (80 hours required**)**

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

_____

_____

_____

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

_____ _____
Physician's Signature Date

ATTACHMENT 2

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Statement of Training for Bone Densitometry Limited License

This form must be completed and signed, bearing the original signature, by the manufacturer or its authorized representative or by a person holding a certificate in bone densitometry and who has received machine specific training by the manufacturer.

Name of Applicant: _____

Social Security Number: _____

I hereby certify that the above named Radiologic Imaging Professional has obtained training as required in rules and regulations 0880-15-.08(3)(b)(c) pertaining to bone densitometry.

_____ Bone Densitometry

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

_____

_____

_____

_____
Manufacturer/Representative/Lic. Bone Densitometry Operator (Please Print)

_____ _____
Manufacturer/Representative/Lic. Bone Densitometry Operator (Signature) Date