Rev 02/12

INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR LICENSURE AS A RADIOLOGIST ASSISTANT

(This form has been designed for use as a checklist for submitting required documentation)

☐ Application and Fee – The application fee is non-refundable.

☐ Employment Activity Questionnaire (Form B) – Forward Form B to all places of practice/employment listed for the past five (5) years or since graduation, if less than five (5) years. If hired by contractors, provide a list of assignments with addresses. This form may be faxed

☐ Jurisdiction – Verification from all jurisdictions in which you have been issued a full license, certification or registration must be received by the Board. Please contact the applicable jurisdictions first to inquire about processing fees. This document may be faxed directly from the jurisdiction.

☐ Transcripts – Transcripts must be official, with the school seal. Transcripts will be accepted if they come directly from the school to the Board or if sent to the Board by the applicant in a sealed envelope. This document may not be faxed.

☐ Form E – This form should be mailed directly from the ARRT to the board office. This documentation may not be faxed. Certification must be requested from:

The American Registry of Radiologic Technologist
1255 Northland Drive
Mendota Heights, Minnesota 55120-1155,
(651)687-0048
www.arrt.org

Please note:

*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, two addresses may be on file with the Board of Medicine. One is made available to the public. You may provide a confidential address of record for Board mailings only and a second, public address. If only one address is provided, it will be your confidential and public address.

*Applications not completed within 6 months may be purged without notice from the board. Applications not completed within one year are considered inactive. Applicants who would like to continue the process after one year will be required to submit a new application and fee.

*Additional information may be requested after review by board representatives.

**Application fees are non-refundable.*

*Do not begin practice prior to Board approval.

*Certain forms may be faxed to 804-527-4426.

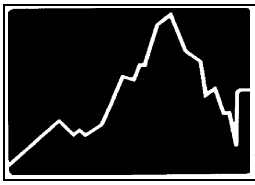
*If you are granted a Virginia license please be advised that continued learning is required after the first renewal cycle following initial licensure. Requirements can be found on the Board's website.

*Contact person Beulah Archer 804-367-3051. Email beulah.archer@dhp.virginia.gov – website: www.dhp.virginia.gov

FORM B - PLEASE CHECK APPROPRIATE PROFESSION

_____, _____
Please Print Last Name Please Print First

- ❑ Acupuncturist
- ❑ Athletic Trainer
- ❑ BCaBA
- ❑ BCBA
- ❑ Chiropractic
- ❑ Genetic Counselor
- ❑ Medicine and Surgery
- ❑ Midwife
- ❑ Occupational Therapist
- ❑ Occupational Therapist Assistant
- ❑ Osteopathy and Surgery
- ❑ Physician Assistant
- ❑ Podiatry
- ❑ Polysomnographic Technologist
- ❑ Radiologic Technologist
- ❑ Radiologic Technologist - Limited
- ❑ Radiologist Assistant
- ❑ Respiratory Therapist



Rev. 7/17

Virginia Department of Health Professions

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Phone: (804) 367-4600
Fax: (804) 527-4426
Email: medbd@dhp.virginia.gov

Please provide name and address of setting/organization exactly as it appears on your application chronology.

_____
Clearly print/type name of applicant

Name of Setting: _____

Address: _____

Last 4 of Social Security Number ___XXX-XX-_____

City, State, Zip: _____

The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past, and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of my application.

Signature of Applicant _____

1. Date and type of service: This individual served with us as _____
   from _____ to _____.
   (Month/Year) (Month/Year)

2. Please evaluate: (Indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (please indicate with check mark) ☐Recommend highly and without reservation ☐Recommend as qualified and competent
   ☐Recommend with some reservation (explain)_____
   ☐Do not recommend (explain) _____

4. Of particular value to us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you. _____
   _____

5. The above report is based on: (please indicate with check mark)
   ☐Close personal observation ☐General impression ☐A composite of evaluations
   ☐Other: _____

Date (Required): _____

Signator Contact Number: (_____) _____

Signed by: _____
Print or type name: _____
Title: _____

(This report will become a part of the applicant's file and may be reviewed by the applicant upon request.)

Print Name: _____

Please complete this form and forward to:

The American Registry of Radiologic Technologists
1255 Northland Drive
Mendota Heights, Minnesota 55120
FAX #: 651-681-3297

I am applying for licensure to practice as a radiologist assistant in the Commonwealth of Virginia and am requesting a report of ARRT certification be forwarded to the address below:

Virginia Board of Medicine – Radiologic Technologists
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
804-367-3051

Name: _____
First Middle Last

Address: _____

_____

_____

Date of Birth: _____ Social Security #: _____

Daytime Telephone #: ( ) _____

ARRT Registry #: _____

Name Certified By (If different from above): _____

Month/Year of Examination: _____

_____
Applicant's Signature