

**INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE AS A RADIOLOGIC
TECHNOLOGIST IN VIRGINIA**
**THIS IS NOT THE APPLICATION FOR LIMITED RADIOLOGIC TECHNOLOGIST OR RADIOLOGIST
ASSISTANT.**

(This form has been designed to be used as a checklist when preparing to submit your application.)

APPLICATION FEES ARE NONREFUNDABLE

BEFORE YOU PROCEED, READ THE FOLLOWING POINTS CAREFULLY!

DO NOT BEGIN PRACTICING BEFORE YOU ARE ISSUED A LICENSE.

This is the application for a license to practice as a Radiologic Technologist.

You should familiarize yourself with the qualifications required for a license by reviewing the laws and regulations governing the practice of radiologic technology in Virginia. They can be found at:

http://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm

The Board works as efficiently as possible to process applications. The time from filing an application with the Board until the issuance of a license is dependent upon entities over which the Board has no control. It is the applicant's responsibility to ensure that outside entities send the necessary documentation to the Board.

The Board provides an electronic checklist for your convenience in tracking your application. You should allow approximately 10 business days for your application checklist to be first updated on the Board's website.

Supporting documentation will be added to your checklist as it is received. Processing of documents may take up to 10 business days after they are received. If you find your checklist does not exist or does not indicate necessary documents have been received, e-mail the Board at medbd@dhp.virginia.gov, with "Radiologic Technologist Application Question" in the subject line. E-mails will be answered within 2 business days.

Your application checklist may be viewed by logging into your application and clicking on the "View Checklist" link located in the Pending Licenses section. This link will not be visible for applicants who have not yet paid the application fee. If you have submitted your application and required fee online, but no longer see your checklist in the Pending Licensing section, your license may have been issued by the Board. Before calling the Board, please visit <https://dhp.virginiainteractive.org/Lookup/Index> to view your newly issued license. This website is primary source license verification that meets the Joint Commission's requirements for license verification. If you need technical assistance with your checklist contact the agency's helpdesk at 804-367-4444. The helpdesk cannot provide assistance regarding information about your documents.

The Board of Medicine discourages the use of the United States Postal Service to send documents. If possible, and if noted below, you are encouraged to have your documents sent by pdf attachment, FAX, FED EX or UPS. The Board is unable to trace documents not delivered by the post office.

Supporting documentation sent to the Board when there is no application on file will be purged after six months.

NB: Virginia law considers material misrepresentation of fact in an application for licensure to be a Class 1 misdemeanor. Misrepresentation may be by commission or omission. Be sure of your facts and provide full responses to the Board's questions.

PROCEEDING TO THE APPLICATION SIGNIFIES THAT YOU HAVE READ AND ACCEPT THE FOREGOING PRINCIPLES REGARDING THE BOARD'S PROCESSES.

INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR LICENSURE AS A RADIOLOGIC TECHNOLOGIST

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

- 1 **Complete the online application** <https://www.license.dhp.virginia.gov/apply/> which includes paying the nonrefundable application fee of \$130.00. Application fees may only be paid using Visa, MasterCard or Discover.
- 2 **Certificate of Professional Education (Form L)** - Form L must be completed by your professional school as directed: If your school is no longer in existence, you may submit a written explanation with a notarized copy of your diploma, or if you received other training accepted by the American Registry of Radiologic Technologists to become certified, written evidence (e.g. notarized copy of original certificate) must be submitted to the board. This documentation **may not** be faxed or emailed.
- 3 **Form E** - This form should be mailed directly from the ARRT to the board office. This documentation **may not** be faxed or emailed. 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

Items 4-6 are not required if you have never practiced your profession and you have never held licensure in another jurisdiction.

- 4 **Employment Activity (Form B) Questionnaire** – All applicants must list all activities from the date of graduation from your professional school including but not limited to internships, employment, affiliations, periods of non-activity or unemployment, observerships and volunteer service in the “Employment Activity” section of the application beginning with your first activity following professional school graduation. If you are employed by a group practice or locum tenens/traveler company, please list all locations where you have provided service or held privileges. Follow this link to obtain a Form B:

[Form B - Hospital/Employment History Questionnaire](#)

For further information related to completing Form B's please review the following guidance document before contacting the Board of Medicine: [Guidance on Completing Form B Employment Verifications, adopted December 1, 2017](#)

Form B's sent to the Virginia Board of Medicine by the applicant will not be accepted.

A completed Form B Activity Questionnaire or a letter of recommendation must be received from all locations of service, places of practice or professional employment, observerships, professional research positions or professional volunteer service listed for the 2 years immediately preceding application. Form B's completed by a non-medical professional may not be accepted.

For applicants practicing as travelers, have the company you are affiliated with provide a complete list of all locations and dates where you have provided service. Form B employment verifications must be received from each location of service for the past 2 years.

Completed Form B's may be attached as a PDF and sent to medbd@dhp.virginia.gov, faxed to (804) 527-4426 or mailed by the person completing the document.

- 5 **NPDB Self Query – Complete the online [Place a Self-Query Order](#) form.** Be ready to provide:
- Identifying information such as name, date of birth, Social Security number
 - State health care license information (if you are licensed)
 - Credit or debit card information for the \$4.00 fee (charged for each copy you request)

Verify your identity. This can be done electronically as part of your order or by completing a paper form and having it notarized. You will receive full instructions as you complete your order.

Wait for your response. Once your identity is verified, the NPDB will process your order. A paper copy of your response will be sent the next business day by regular U.S. mail.

The Board does not accept emailed copies of the NPDB report. When you receive your report in the mail from NPDB **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board of Medicine. The Board recommends using Fed EX or UPS for tracking purposes. The Board of Medicine is unable to track any mail or other package that is sent via the United States Postal Service.**

Any NPDB report received for an application not completed within 3 months of receipt of the NPDB report will have to be resubmitted.

- 6 **License Verification**–Verification of radiologic technologist licenses from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a license/certificate or registration must be received by the Board. **Please contact the applicable jurisdiction where you have been issued a license to inquire about having verification forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by fax to (804) 527-4426, email to medbd@dhp.virginia.gov, or mailed.

Please note:

▶ Applications not completed within 12 months may be purged without notice from the board. Applications not completed within 12 months are considered inactive. Applicants who would like to continue the process after 12 months will be required to submit a new application and fee.

▶ Virginia is a direct verification state. All supporting documents must come from the original source unless specifically noted in the instructions.

▶ Additional information not already listed may be requested at any time during the process.

▶ Application fees are non-refundable.

▶ The Board's mailing address is

**The Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233**

▶ Email inquiries are normally responded to within 2 business days. Send your email inquiries to medbd@DHP.Virginia.gov. Please include “**Radiologic Technologist Application**” in your subject line.

▶ Submission of an application does not guarantee a license. A review of your application could result in the finding that you may not be eligible pursuant to Virginia laws and regulations.

*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

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Genetic Counselor | <input type="checkbox"/> Osteopathy and Surgery | <input type="checkbox"/> Radiologic Technologist |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Medicine and Surgery | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Radiologic Technologist - Limited |
| <input type="checkbox"/> BCaBA | <input type="checkbox"/> Midwife | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Radiologist Assistant |
| <input type="checkbox"/> BCBA | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Polysomnographic Technologist | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Occupational Therapist Assistant | | |



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): _____

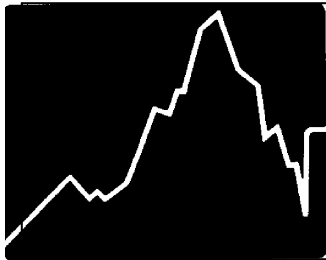
Signed by: _____

Print or type name: _____

Signator Contact Number: (_____) _____

Title: _____

Print Name: _____



Department of Health Professions
Commonwealth of Virginia

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

FAX (804) 527-4426
(804) 367-3051

To Whom It May Concern:

The person listed below is applying for a license to practice as a radiologic technologist in the Commonwealth of Virginia. The Board of Medicine requests that the form be completed by each jurisdiction in which he/she holds or has held a license/certificate. Please complete the form and return it to the address below. Thank you.

Commonwealth of Virginia
Department of Health Professions
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Name of Applicant (Please print or type.)

License/Certificate #

=====

Name of Licensee _____ State/Commonwealth of _____

License/Certification number _____ Issued effective _____

Licensed/certified through (check one)

National Examination State Board Examination Reciprocity from (Name of State) _____

License/certificate is: Current Lapsed

Has the applicant's license/certificate ever been suspended or revoked? Yes No

If yes, for what reason?

Derogatory information, if any

Comments, if any

BOARD SEAL

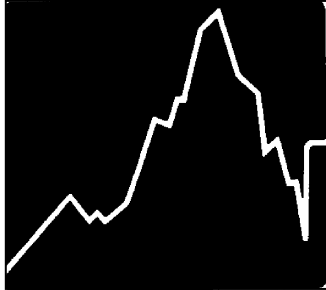
Signed _____

Title _____

State Board _____

NOTE TO APPLICANT: PLEASE PROVIDE LICENSE NUMBER AND FORWARD TO STATE INDICATED

Print Name at present _____



Department of Health Professions
Commonwealth of Virginia

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

(804) 367-3051

Submit this form to your professional school for completion. For identification purposes, provide your full name at the time of graduation and date of graduation. Instruct your school to return the completed form directly to the Virginia Board of Medicine.

Certificate of Professional Education

It is hereby certified that _____
(Name of Applicant)

enrolled in _____ on _____
(Course of Study) (Date)

and received a diploma from _____
(Name of Institution)

conferring the degree of _____ on _____
(Degree) (Date)

(President, Secretary or Dean)

SCHOOL SEAL

Completed form must be mailed to:

Beulah Archer, Licensing Specialist
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

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 radiological technology in the Commonwealth of Virginia and am requesting that a letter of good standing be forwarded to the address below:

Virginia Board of Medicine – Beulah Archer
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		



NMTCB VERIFICATION

Please complete this form and forward to:

Nuclear Medicine Technology Certification Board
3558 Habersham at Northlake, Building I
Tucker, GA 30084-4009
FAX #: 404.315.6502

I am applying for licensure to practice Nuclear Medicine Technology in the Commonwealth of Virginia, and am requesting that my NMTCB certification be verified to the Virginia Board of Medicine to the address below:

Virginia Board of Medicine – Beulah Baptist Archer
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Fax: 804.527.4426

Name: _____

Address: _____

City _____ State _____ Zip _____

Daytime Phone# _____ Email: _____

NMTCB Certificate#: _____

Name Certified by (If different from above): _____

Month and Year of Examination _____

Applicant's Signature