Rev. 12/15

INSTRUCTIONS FOR REINSTATEMENT OF A RADIOLOGIC TECHNOLOGIST LICENSURE APPLICATION

"Reinstatement occurs after the license has been expired for 2 years."

A completed application must be returned to this office along with the reinstatement fee. The fee for reinstatement is $180.00. APPLICATIONS WILL NOT BE PROCESSED UNLESS THE FEE IS ATTACHED. Checks or money orders should be made payable to the "Treasurer of Virginia".

INFORMATION REQUIRED TO COMPLETE YOUR APPLICATION

(This form has been designed to be used as a checklist for submitting required documentation.)

☐1. If you answer "yes" to any of the licensure questions #5-15 provide a written explanation on a separate piece of paper and attach it to the application. If you have disciplinary action with another Board, also attach a copy of the Board Order or other documentation. If you have medical mal practice claims attach a narrative that includes dates, your treatment of the patient and any payment made per settlement or judgement. You may also provide a letter from your attorney. If you have misdemeanor or felony convictions attach a copy of the court documents. .

☐2. Forward Form B **(Activity questionnaire)** to all hospitals, clinics, doctor's offices and all other locations where you have provided professional service since your Virginia license expired but for no more than the past 5 years. This form may be copied, if necessary. This document **may** be faxed to the Board by the person completing it or sent via email to medbd@dhp.virginia.gov.

☐3. Verification of radiologic technology licenses from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a full license must be received by the Board. **Please contact the applicable jurisdiction where you have been issued a license to practice as a radiologic technologist to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to medboard@dhp.virginia.gov, faxed to (804) 527-4426 or mailed.

☐4. Provide documentation verifying completion of 24 hours of continuing education acceptable to the ARRT within the two years preceding the date of your reinstatement application.

☐5 . Copies of documentation supporting any name change since your initial licensure in Virginia.

Please note:

Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, addresses on file with the Board of Medicine are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, with the application of new technology, which makes this information more accessible, there has been growing concern of those licensees who supply their residence address for mailing purposes. This notice is to reiterate that the Board of Medicine maintains only one address for each licensee and will allow the address of record to be a Post Office Box or practice location.

Applications will be acknowledged after receipt of the application of items that are missing.

Applications not completed within 12 months may be purged without notice from the board.

Additional information may be requested after review by Board representatives.

Application fees are non-refundable.

Do not begin practice until you have been notified of approval. 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.

Certain forms may be faxed to 804-527-4426.
The Phone number to the Virginia Board of Medicine is 804-367-4600
The Board's email address is medbd@dhp.virginia.gov

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

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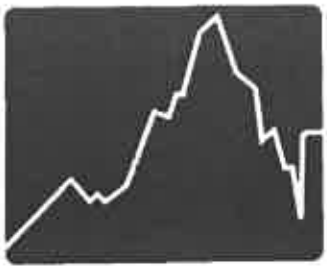
RADIOLOGI TECHNOLOGIST REINSTATEMENT APPLICATION:



COMMONWEALTH OF VIRGINIA

BOARD OF MEDICINE

Department of Health Professions
9960 Mayland Drive, Ste. 300
Henrico, Virginia 23233-1463

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

Application for REINSTATEMENT of license To Practice Radiologic Technology

To the Board of Medicine of Virginia:
I hereby make reinstatement application for a license to practice as n radiologic technologist in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle	
Street	City	State	ZIP Code
Date of Birth ____ ____ ____ Mo. Day Yr.	Place of Birth	Social Security No. or VA Control No.*	
Graduation Date ____ ____ ____ Mo. Day Yr.	Prof. School Degree	School, City, State	**MAIDEN NAME**

Please submit address changes in writing immediately.
Please attach check or money order. Application will not be processed without the fee. It will be returned.
Do not submit fee without an application. **IT WILL BE RETURNED.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY

_____

Date

LICENSE NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
0120-	$ 180		

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices to include the location of service since the expiration date of your Virginia license including any periods of non-professional activities or employment. **Please account for all time.** If there has been no practice, please explain. **<u>CVs may be attached but do not substitute for completion of this page.</u>**

From	To	Name and Location	Position Held

Please provide a telephone number where you can be reached during the day. This information is not mandatory and if provided, will not be used for any purpose other than as a contact if staff has questions about your application.

Work Number	Home Number	Email Address

QUESTIONS MUST BE ANSWERED. If any of the following questions (5-15) is answered **Yes**, explain and substantiate with documentation. Letters may be submitted by your attorney regarding malpractice suits

3. Do you intend to engage in the active practice of radiologic technology in the Commonwealth of Virginia? ☐ Yes ☐ No

4. List all jurisdictions in which you have been issued a license to practice radiologic technology and the status as active, inactive or expired. Indicate the license number and the date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

	Yes	No
5. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?	____	____
6. Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving.	____	____
7. Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges for any reason?	____	____
8. Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or requested to withdraw from any professional school, training program, hospital, etc.?	____	____
9. Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier?	____	____
10. Have you ever had any disciplinary actions taken against any of your professional license/certificate/permit/registration related to your professional practice, are any actions pending or are you currently under investigation?	____	____
11. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned?	____	____
12. Have you voluntarily withdrawn from any professional society while under investigation?	____	____
13. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties?	____	____
14. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two (2) years?	____	____
15. Have you been in a health practitioner's monitoring program within the last two (2) years?	____	____
16. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia?	____	____

14. AFFIDAVIT OF APPLICANT

I, _____, attest that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all 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 individuals and groups listed above, any information which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice medicine and surgery in the Commonwealth of Virginia.

_____

Signature of Applicant

Rev. 12/15 Radiologic Technology Form B

Department of Health Professions
Commonwealth of Virginia

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

Applicant: Please print/type name and location of organization completing this form (Should match organization listed on employment activity page of application)

_____

_____

_____

_____

Please clearly print/ type name of Applicant

Applicant's Date of Birth: _____

The Virginia Board of Medicine, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate'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 this candidate's 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 _____

Item #1 must be completed, or form may be invalid

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 candidate regarding 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: _____
Title: _____

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