



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

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION INSTRUCTIONS FOR LICENSURE AS A RADIOLOGIST ASSISTANT

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice as a Radiologist Assistant.

ALL APPLICATION FEES ARE NON-REFUNDABLE.

- | | Done |
|--|-------------|
| 1. Complete, have notarized, and mail the application pages 1 through 6. | _____ |
| 2. Copy of ARRT identification card which must be current, in good standing and show certification as a Radiologist Assistant (RA) and as a Radiologic Technologist (RT). | _____ |
| 3. Copy of certification in Advanced Cardiac Life Support (ACLS) which must be current and in good standing. | _____ |
| 4. Submit a clear and recognizable recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. | _____ |
| 5. Copy of x-ray operator's license from the Tennessee Board of Medical Examiners that is current and unencumbered. | _____ |
| 6. On or after July 1, 2008 cause to be provided directly to this office from the school a transcript showing graduation from a radiologist assistant education program, and that a baccalaureate degree or its equivalent from an institution offering a program accredited by an entity recognized by the American Registry of Radiologic Technologists for certification purposes, which includes a radiologist directed clinical preceptorship has been conferred, and contains the official seal of the institution. (Attachment 1) | _____ |
| 7. Complete and have supervising physician fill out and attest to credentials as a radiologist and acknowledge responsibility to supervise radiologist assistant. (Attachment 2) | _____ |
| 8. Attach to the application a check or money order in the amount of \$60 made payable to the Board of Medical Examiners. | _____ |
| 9. Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. Click here for instructions. | _____ |
| 10. Complete Attachment 4 – Declaration of Citizenship | _____ |

UNDERSTANDING THE APPLICATION PROCESS

1. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Medical Examiners
ATTN: Radiologist Assistant
665 Mainstream Drive
Nashville, TN 37243**

2. 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 asks that you please give the Board office every consideration in this matter.
3. 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 by 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.
4. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination. Application approval may also be accessed through our webpage at www.tennessee.gov and click on licensure verification.
5. It is recommended that you do not make arrangements to accept employment as a radiologist assistant in Tennessee until you are granted a license by the Board of Medical Examiners.
6. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners
ATTN: Radiologist Assistant
665 Mainstream Drive
Nashville, TN 37243

For Federal Express or Special Courier:
Tennessee Board of Medical Examiners
ATTN: Radiologist Assistant
665 Mainstream Drive
Nashville, TN 37228

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

For Official Use Only

1638/001	\$ 50.00
1638/006	\$ 10.00

ATTACH A
CURRENT FULL-
FACE
PHOTOGRAPH



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APPLICATION FOR LICENSE AS A RADIOLOGIST ASSISTANT

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

Date of Birth _____
(Month) (Day) (Year)

Social Security # _____

Current Home Mailing Address

Home Phone (_____) _____

Current Practice Address

Work Phone (_____) _____

Email address: _____

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

EDUCATIONAL AND EMPLOYMENT INFORMATION

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

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

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES

LOCATION

FROM: _____ TO: _____

POSITION AND DUTIES _____

FROM: _____ TO: _____

POSITION AND DUTIES _____

FROM: _____ TO: _____

POSITION AND DUTIES _____

FROM: _____ TO: _____

POSITION AND DUTIES _____

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 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. **“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 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	Yes	No
2. Do you currently use chemical substances as defined on page 4?	_____	_____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
Please List: _____ _____ _____		
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?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice as a x-ray operator or radiologist assistant in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, 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, 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 a final judgment rendered <u>against</u> you; *	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or *	_____	_____
c. Are there any legal actions pending <u>against</u> 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, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? *	_____	_____

***Affirmative responses require final documents or orders from the issuing states, courts, and/or agencies.**

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, attests 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 as a radiologist assistant 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 a radiologist assistant.

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 certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing 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

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

NOTARY PUBLIC

Affix Seal Here

My Commission expires: _____



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BOARD OF MEDICAL EXAMINERS RADIOLOGIST ASSISTANT
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www.tennessee.gov

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your radiologist assistant program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a radiologist assistant in the State of Tennessee. The Board requires verification of educational attainment. Please forward an original transcript bearing your institution's official seal to the Board's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

Applicant's Social Security Number: _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

**Tennessee Board of Medical Examiners
Radiologist Assistant
665 Mainstream Drive
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date

Applicant's Name: _____



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SUPERVISING PHYSICIAN

This section must be completed by the supervising physician.

I, _____ certify that I am a radiologist
and take the responsibility to supervise _____
as a Radiologist Assistant.

Supervising Physician Signature

Date

Printed Name

License Number

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

Notary Public

Affix Seal Here

My Commission Expires _____



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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please complete the top portion of this form and forward it to the regulatory board in each state where you hold or have held a license to practice any profession. (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 or states.

I was granted a license or certificate to practice _____ numbered _____
on _____ by the State of _____
Date

The Tennessee Board of Medical Examiners request 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: Tennessee Board of Medical Examiners, ATTN: Radiologist Assistants, 665 Mainstream Drive, Nashville, Tennessee 37243.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

THIS PORTION IS TO BE COMPLETED BY STATE REGULATORY BOARD:

License Number: _____ Date Issued: _____

Profession _____

Basis of Issuance: _____ Endorsement/Reciprocity With: _____

Written Examination: _____
(Provide Description of Exam)

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No (If "yes", please attach explanation)

Authorized Signature Title Date



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 HEALTH RELATED BOARDS
 665 MAINSTREAM DRIVE
 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) _____ <p style="text-align: center; margin: 0;">Healthcare Profession (Please Print)</p>	_____ <p style="text-align: center; margin: 0;">License number if applicable</p>
---	---

Please Print Legibly

1. Name: _____
 Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) 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.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) 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.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) 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.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) 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.
- h) 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** (question 7 above), please submit two 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 are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

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__.

NOTARY PUBLIC

AFFIX SEAL HERE

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.