

CRIMINAL RECORDS CHECK REQUIRED FOR INITIAL LICENSURE **RADIOLOGIST ASSISTANT**

Chapter 4774 of the Ohio Revised Code requires all individuals applying for a new license or restoring a license as a radiologist assistant with the State Medical Board of Ohio to submit fingerprints for a criminal records check completed by the Ohio Bureau of Criminal Identification and Investigation (BCI) and the Federal Bureau of Investigation (FBI).

ALL applicants are required to utilize “WebCheck”, Ohio’s electronic fingerprint system, to electronically submit their fingerprints to BCI. The Board will typically receive the results of criminal records check submitted via “WebCheck” with 7 to 10 business days. In addition to the \$22 BCI fee and \$24 FBI fee, the electronic fingerprinting company/agency will charge an additional handling fee to process the fingerprints.

Since the law requires applicants for licensure to submit a criminal records check completed by both BCI and the FBI, applicants **MUST** use the services of a vendor that has the indicator (BCI and FBI) after its name. The Sheriff’s office in most Ohio counties has this capability, as do a wide variety of agencies and companies. A list of all vendors, searchable by county, is available online at:

<http://www.ohioattorneygeneral.gov/Business/Services-for-Business/WebCheck/Webcheck-Community-Listing>

When choosing an electronic fingerprinting vendor from the WebCheck Community Listing, you MUST use the services of a vendor that has (BCI and FBI) listed after the vendor’s name. Only these entities are able to submit prints for both the BCI and the FBI records check. The Board does not endorse or recommend any specific electronic fingerprinting company/agency.

You need both the BCI and FBI criminal records check for initial licensure and license restoration. By law, the Board cannot complete the processing of your application until it receives the background check reports from both BCI and FBI.

Steps for “WebCheck”

1. Identify a “BCI and FBI” vendor on the WebCheck Community Listing.
2. Submit your fee directly to the vendor. **DO NOT SEND YOUR FINGERPRINTS OR FEE TO THE BOARD.**
3. Request that the criminal records check results from both BCI and FBI be sent directly to:

**State Medical Board of Ohio
30 E. Broad St., 3rd Floor
Columbus, Ohio 43215-6127**

Indicate the reason for fingerprinting as: “Required for licensure per ORC 4774.031”.

List the agency code as **1AB002**.

Instructions for Individuals Residing Outside Ohio

Individuals residing outside Ohio who do not want to travel to Ohio to use a vendor from the WebCheck Community Listing must contact the Board by email at med.license@med.state.oh.us to request the appropriate forms. The Board will mail the forms needed for your fingerprints to be processed at your local law enforcement agency.



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

RE: Radiologist Assistant

Attached is an application and instructions for a Certificate to Practice as an Radiologist Assistant in the State of Ohio.

You may **NOT** begin practice in Ohio until your application has been approved and you have been issued a certificate number. The application processing time is approximately sixty (60) days after receipt of an application and fees by the Board. An incomplete application or any unusual circumstances may delay processing. Please be advised that your application will not be deemed complete until all fees, properly completed forms and any additional required documentation are received by the Board. All information submitted will be thoroughly investigated and individuals will be contacted regarding your application as the Board deems necessary.

Information governing Radiologist Assistants may be found on the Board's website at <http://med.ohio.gov>. As a Radiologist Assistant in the State of Ohio you will be responsible for keeping up-to-date with the laws governing your profession. Section 4774.06, Ohio Revised Code, requires biennial renewal of the certificate to practice. To ensure that you receive your renewal notices timely, update your home or business address within thirty days of any change.

Upon issuance of an Ohio certificate number, a letter of notification will be sent to you. That letter will serve as legal authorization to practice in Ohio. A wall certificate will be mailed approximately 3-4 weeks after registration. Please be advised that verification of your certificate to practice status must be obtained directly from the Board's website at <http://med.ohio.gov> in the "Licensee Profile and Status" section. The website is updated immediately to reflect newly issued licenses.

Attachments:

INSTRUCTIONS FOR APPLICATION FOR CERTIFICATE TO PRACTICE RADIOLOGIST ASSISTANT

Review the following instructions and the entire application packet carefully before completing the application. Processing will not begin until the appropriate fee is received. Failure to submit all required information and documentation will result in processing delays.

1. Complete the enclosed **APPLICATION FOR CERTIFICATE TO PRACTICE AS A RADIOLOGIST ASSISTANT** in its entirety. You must provide a response to each section or question of the application as instructed. Mark "N/A" if Not Applicable.
2. Submit a check or money order in the amount of **\$200.00** made payable to **Treasurer, State of Ohio** with your application. **DO NOT SEND CASH. FEES ARE NEITHER REFUNDABLE NOR TRANSFERABLE.**
3. Request a criminal records check from the Ohio BCI and FBI (refer to the Criminal Records Check instruction sheet for additional information).
4. Complete the Resume of Activities. List all activities in chronological order from the date you began your Radiologist Assistant training to the present or the last five years, whichever is longer. Do not substitute any other resume or CV for this form. Have your most recent employer submit a letter of recommendation which includes the period of employment.
5. Answer all questions under the Additional Information portion of this application. All affirmative answers must be thoroughly explained and supporting documentation submitted as requested.
6. The Affidavit and Release of Applicant must be signed and notarized.
7. Attach a recent (taken within the last six months) passport-type **COLOR** photo to each of the two Certificates of Good Moral Character (Form 1), sign and date beneath your photographs, and forward to the two persons who will complete these recommendations. The physician you choose to complete Form 1A must be fully licensed in the state in which the form is notarized. Black and white photos will not be accepted.
8. Complete the top portion of the enclosed Verification of License/Registration (Form 2) and forward it directly to each state in which you hold or have held a license/registration as a Radiologist Assistant , **whether now current or not**. You **MUST** have the state licensing authority send the completed form **directly** to this Board. Photocopies of the form may be made.
9. Complete the top portion of the enclosed Verification of Radiologist Assistant Training Program (Form 3) and forward it to your program in order for them to certify that you have completed the required didactic education as well as the requisite clinical course work. Also submit a photocopy of any certificate of graduation or diploma from your Radiologist Assistant training program.
10. You **MUST** have the American Registry of Radiologic Technologists (ARRT) send certification **directly** to this Board that you hold current certification as a registered radiologist assistant.
11. Submit documentation that you hold current certification in advanced cardiac life support.
12. If you have changed your name, you **MUST** submit a copy of the appropriate legal document that authorizes each name change. This may be a court decree or a marriage certificate.
13. Mail your completed application and fee directly to the Ohio Board at the following address:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, OH 43215-6127



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

APPLICATION FOR CERTIFICATE TO PRACTICE RADIOLOGIST ASSISTANT SECTION 4774.03. OHIO REVISED COE

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is \$200.00. Fees submitted are neither refundable nor transferable.

IDENTIFICATION

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number		_____			
Full Name (Use no initials)	Last	First	Middle	Suffix (Jr., II)	
Maiden Name or other names used (If none, enter "NONE")	Last	First	Middle	Dates Used From: ____/____/____ To: ____/____/____	
Current Home Address IMPORTANT Notify the Board office immediately, in writing, of any change in address	Number & Street			Apt.	
	City		State	Zip Code	Country
Anticipated Practice Address	Number & Street				
	City		State	Zip Code	
Telephone Number	area code & number Business: (____) _____		area code & number Home: (____) _____		
Birth Date	month/day/year / /	Birth Place	City	State	Country
Email Address					
Gender	<input type="checkbox"/> Male		<input type="checkbox"/> Female		For statistics only (optional)

EDUCATION AND TRAINING

List any post high school education as well as Radiologist Assistant programs, including address, dates of attendance and degree received, if any (attach separate sheet, if necessary). **A Form 3, Verification of Training Program form must be sent to your radiologist assistant school for completion.**

Name of University, School or Institution	School Name			
	City	State	Country	
Dates Attended	From: mo/yr /	To: mo/yr /	Degree Received (if any)	

Name of University, School or Institution	School Name			
	City	State	Country	
Dates Attended	From: mo/yr /	To: mo/yr /	Degree Received (if any)	

AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS			
List ALL examinations you have taken. You must have the American Registry of Radiologic Technologists send certification that you have passed their examination.			
Month/Year			
Date: _____ / _____	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pending
Date: _____ / _____	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pending
Date: _____ / _____	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pending

REGISTRATIONS/LICENSES IN THE UNITED STATES OR CANADA			
List ALL states/provinces (including Ohio) in which you hold or have ever held a registration/license/certificate as a Radiologist Assistant or Radiographer. Indicate the license number, date of issuance and whether or not the license is current. If additional space is needed, attach an extra sheet. (If none, enter "NONE"). A Form 2, Verification of License/Registration form must be sent to verify each license listed.			
STATE	ISSUE DATE month/year /	LICENSE #	LICENSE CURRENT
	/		<input type="checkbox"/> YES <input type="checkbox"/> NO
	/		<input type="checkbox"/> YES <input type="checkbox"/> NO
	/		<input type="checkbox"/> YES <input type="checkbox"/> NO

Applicant Name: _____ Date: _____

Radiologist Assistant Resume of Activities

List **ALL** activities in chronological order from the date you began your radiologist assistant training to the present time or the last five years, whichever is **LONGER**, using **MONTH** and **YEAR**. For any non-working time, you **MUST** state on the resume exactly what your activities were, such as "vacation" or "looking for work", as well as your permanent home address. **DO NOT SUBSTITUTE ANY OTHER RESUME OR CV FOR THIS FORM**. If additional space is needed, please attach separate sheets.

Have your most recent employer submit a letter of recommendation which includes the period of employment, if applicable.

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

Applicant Name: _____

Date: _____

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

From	Employer or Non-working Activity	Position
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		
To	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Full Address, including city, state, zip code	
<div style="border: 1px solid black; padding: 2px; text-align: center;">Month/Year /</div>		

**Radiologist Assistant
Additional Information Questions**

If you answer "YES" to any of the following questions, **you** are **required** to furnish complete details, including date, place, reason and disposition of the matter. **All affirmative answers must be thoroughly explained on a separate sheet of paper.** Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a in the yes or no box)

		YES	NO
1.	Have you ever been terminated, or have you ever been requested to resign from, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you, or imposed a fine or reprimand against you?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by any board, bureau, department, agency, or other body; including those in Ohio?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate or registration, in lieu of formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license, certificate or registration?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license, certificate or registration?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever been denied licensure, certification or registration, application for licensure, certification or registration, or privilege of taking examination, or have you ever withdrawn any application in any state (including Ohio), territory, province or country for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? Please be advised that you are required to submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name: _____

Date: _____

		YES	NO
10.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit (other than a malpractice suit) filed against you? Please be advised that you are required to submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you been a defendant in a legal action involving professional liability (including malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, you must complete the enclosed malpractice claim information form. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced or terminated by the Department of Defense or the Veteran's Administration?	<input type="checkbox"/>	<input type="checkbox"/>

* * * * *

		YES	NO
14.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
15.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		

Applicant Name: _____ Date: _____

For purposes of questions 16 and 17 the following phrases or words have the following meaning:

“Ability to practice as an Radiologist Assistant” is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical assessments and exercise reasoned judgments and to learn and keep abreast of developments in the field of Radiologist Assistant; and
2. 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
3. The physical capability to perform tasks such as the performance of Radiologist Assistant, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Medical condition” includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
16.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice as an Radiologist Assistant with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain. If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk 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. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	<input type="checkbox"/>	<input type="checkbox"/>
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name: _____

Date: _____

“*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 prescribers direction, as well as those used illegally.

		YES	NO
17.	Do you use chemical substance(s) which in any way impair or limit your ability to practice as an Radiologist Assistant with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain. If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk 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. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	<input type="checkbox"/>	<input type="checkbox"/>
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

For purposes of question 18 the following phrases or words have the following meaning:

“*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 may have an ongoing impact on one’s functioning as a licensee, or within the past two years.

“*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 direction of a licensed healthcare practitioner.

		YES	NO
18.	Are you currently engaged in the illegal use of controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
	a) If “YES,” are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name: _____

Date: _____

**RADIOLOGIST ASSISTANT
LICENSURE MALPRACTICE QUESTIONNAIRE**

This form must be completed if you have been named as a defendant in a malpractice lawsuit, verdict or settlement. *Make additional copies of this form as necessary for multiple claims.*

Applicant Name (print clearly): _____

MALPRACTICE COMPLAINT:

Name of Patient: _____

Patients Gender: Male Female Age of Patient: _____

Date of Incident: _____ Date Suit Filed: _____

Location of incident: _____

Hospital, institution or other

Address

City

State

Zip Code

County

Name and Address of Involved Insurance Carrier: _____

FILED AGAINST: Individual Physician Group Hospital

Your Position in Case: Resident Primary Other: _____

List names of other defendants-(physicians and/or hospitals): _____

DISPOSITION: Pending Jury Verdict Settled Dismissed

Dropped

If settled, provide the following information: In Court Out of Court

Name of Court: _____

Date of Settlement: _____ Docket #: _____

Total amount of settlement: \$ _____ Amount attributable to you: \$ _____

You must provide a detailed written explanation of the background and medical issues involved in the case. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach separate sheet. Submit copies of the complaint, answer, release, settlement documents and all other relevant legal documents. **Be sure to have your malpractice insurance carrier(s) provide a complete claims history report.**

Signature

Date

**RADIOLOGIST ASSISTANT
AFFIDAVIT AND RELEASE OF APPLICANT**

The affidavit and release MUST be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: _____
 COUNTY OF: _____

I, _____, hereby certify under oath that I am the person named in this application for a Certificate to Practice as a Radiologist Assistant in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the instructions for all applicants and I have answered all questions in compliance with these instructions. I understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a Certificate to Practice as a Radiologist Assistant in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice as a Radiologist Assistant. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for a Certificate to Practice as a Radiologist Assistant and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent registration or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution, or to any professional association.

I further understand that consideration of this application is based on the truth of the statements and documents made or furnished in connection with it. If any of the statements are false, I may be permanently denied a certificate to practice as a Radiologist Assistant in Ohio.

Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20 _____

Signature of Notary Public

(NOTARY SEAL)

Date Commission Expires



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

RADIOLOGIST ASSISTANT FORM 1A - CERTIFICATE OF GOOD MORAL CHARACTER

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommenders. The recommending physician must sign this form in front of a notary. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED
BLACK & WHITE PHOTOS WILL NOT BE ACCEPTED

I, _____, a licensed and practicing physician in the state of _____
(recommending physician, print name legibly) (state of residence)

affirm that _____, has been known to me personally for _____ years and
(applicant, print name legibly)

that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant.

I hereby recommend him/her for a registration as an Radiologist Assistant in the State of Ohio.

Address of Recommending Physician	Number & Street	Telephone Number (include area code)	
	City State Zip Code		
Signature of Recommending Physician (name stamps not accepted)		State of Licensure & License Number	

PHOTOGRAPH

Applicant: Staple a recent passport-type size **COLOR** photo of yourself here; must have been taken within the last six months

(black & white photos will not be accepted)

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public Signature

Date Commission Expires

Signature of Applicant

Date Photo Taken: _____ / _____
month/year

NOTARY SEAL



State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

RADIOLOGIST ASSISTANT FORM 1B - CERTIFICATE OF GOOD MORAL CHARACTER

This form is to be completed by a resident of the state in which you are residing. They must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommenders. The recommender must sign this form in front of a notary. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED **BLACK & WHITE PHOTOS WILL NOT BE ACCEPTED**

I, _____, affirm that _____, has been
(name of recommender, print name legibly) (name of applicant, print name legibly)

known to me personally and/or professionally for _____ years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant.

I hereby recommend him/her for registration as an Radiologist Assistant in Ohio.

Address of Recommender	Number & Street			Telephone Number (include area code)
	City	State	Zip Code	
Signature of Recommender (name stamps not accepted)				

PHOTOGRAPH

Applicant: Staple a recent passport-type size **COLOR** photo of yourself here; must have been taken within the last six months

(black & white photos will not be accepted)

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public Signature

Date Commission Expires

Signature of Applicant

Date Photo Taken: _____ / _____
month/year

NOTARY SEAL



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RADIOLOGIST ASSISTANT FORM 2 – VERIFICATION OF LICENSE/REGISTRATION

I am applying for a Certificate to Practice as a Radiologist Assistant in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state in which I hold or have held licenses/registrations/certifications, whether now current or not. **Please complete the form and return it to the State Medical Board of Ohio at the above address.** Thank you.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: _____
last first middle suffix (Jr., II)

Registration # _____ Date of Birth _____
month/day/year

I hereby authorize the licensing agency of the State of _____
to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant

Date

THIS SECTION TO BE COMPLETED BY STATE LICENSING AGENCY

State: _____

Name of Licensee: _____
last first middle suffix (Jr., II)

Type of license/registration: _____

License/Registration #: _____ Date Issued: _____
month/day/year

Is the license/registration current? YES NO If not, please explain: _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?
 YES NO Cannot answer under current state law **If yes, please attach complete details.**

Have formal disciplinary proceedings been initiated against applicant or applicant's license/registration by a disciplinary authority in your state?
 YES NO Cannot answer under current state law **If yes, please attach complete details.**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license/registration been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
 YES NO Cannot answer under current state law **If yes, please attach complete details.**

**AFFIX
BOARD SEAL**

**(not valid
without seal)**

Signature

Title

Date



State Medical Board of Ohio

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RADIOLOGIST ASSISTANT FORM 3 – VERIFICATION OF EDUCATION/TRAINING

I am applying for a Certificate to Practice as a Radiologist Assistant in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the program where I received my Radiologist Assistant training. **Please complete the form and return it to the State Medical Board of Ohio at the above address.** Thank you.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: _____
last first middle suffix (Jr., II)

Address: _____
Number & Street Date of Birth _____
month/day/year

City, State & Zip Code

I hereby authorize _____
to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY RADIOLOGIST ASSISTANT PROGRAM

This certifies that the above named applicant has successfully completed the requisite didactic education as well as the requisite clinical course work as defined in Section 4774 Ohio Revised Code and as verified in the applicant's official academic transcripts.

Name of Program: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____
from: _____ to: _____
beginning (month/day/year) ending (month/day/year)

It is further certified that the above named: will be awarded a degree _____
month/day/year
 was awarded a degree on: _____
month/day/year
 was not awarded a degree, explain _____

I hereby recommend him/her for Radiologist Assistant registration in the State of Ohio.

**SCHOOL
SEAL**
**(If none, have
form
notarized)**

Signature of Registrar/Program Director (original signature only, name stamps will not be accepted.)

Name (please print or type)

Date