Reset

Limited X-Ray Machine Operator Permit
Application for Registration

Check Number: _____
Amount: _____

COMPLETE FORM, ENCLOSE $50 FEE AND A CURRENT COPY OF YOUR 12 HOURS OF CONTINUING EDUCATION. ALL INCOMPLETE APPLICATIONS WILL BE RETURNED AND PROCESSING WILL BE DELAYED. A $10 FEE WILL BE ASSESSED EACH TIME AN APPLICATION IS RETURNED DUE TO INCOMPLETENESS. A $50 FEE WILL BE ASSESSED TO ALL RETURNED CHECKS.

MAIL TO: MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
1867 CRANE RIDGE DRIVE, SUITE 200-B
JACKSON, MS 39216

(Please type or print in ink.)

Name : _____ Maiden or other Name : _____

Birth Date: _____ Social Security: _____ Gender: Male _____ Female _____

Place of Employment: _____ Home Address: _____

Supervising Practitioner _____ _____

Employment Address: _____ _____

_____

_____

Additional
Place of Employment: _____ Work Phone Number: _____

Fax Number: _____

Additional
Employment Address: _____ Home Phone Number: _____

_____ Email Address: _____

_____

Have you ever held a Limited X-Ray Machine Operator Permit? _____ Yes _____ No

If yes, enter Permit Number: _____

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true and correct to the best of my knowledge and belief. I understand that I will be limited to specific radiographic procedures on certain parts of the human anatomy, specifically the chest, abdomen and skeletal structures, excluding fluoroscopic and contrast studies, computed tomography (CT), nuclear medicine, radiation therapy studies and mammography.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Supervising Licensed Practitioner Date