MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

1867CRANE RIDGE DRIVE, SUITE 200-B
JACKSON, MISSISSIPPI 39216
(601) 987-3079

APPLICATION FOR LICENSE TO PRACTICE AS A RADIOLOGIST ASSISTANT

1. NAME IN FULL _____
(FIRST) (MIDDLE) (LAST) (DEGREE)

2. ADDRESS _____
(STREET OR P O BOX) (CITY) (STATE) (ZIP)

3. PLACE OF BIRTH _____ DATE OF BIRTH _____
(CITY AND STATE OR COUNTRY) (MM/DD/YYYY)

4. SOCIAL SECURITY # _____ GENDER _____

5. TELEPHONE (W) _____ (H) _____ FACSIMILE _____

		YES	NO
6.	Have you ever been convicted of a felony?		
7.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to your practice as a radiologist assistant?		
8.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?		
9.	Are any charges against you for violation of state or federal drug laws currently pending in any court?		
10.	Has your certificate of qualification or license to practice as a radiologist assistant in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation?		
11.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice as a radiologist assistant?		
12.	Have you ever resigned from the medical staff of any hospital or health care facility while an investigation or disciplinary proceeding was being conducted or pending?		
13.	Have you ever been denied a certificate of qualification or license to practice as a radiologist assistant in any state, or has your application for a certificate of qualification or license to practice as a radiologist assistant been withdrawn under threat of denial?		
14.	Are you now, or have you ever used any controlled substances or other drugs having addiction-forming or addiction-sustaining liability to the extent it affects your ability to practice as a radiologist assistant with reasonable skill and safety to patients?		

		YES	NO
15.	Have you ever obtained any controlled substance or other drug having addiction-forming or addiction-sustaining liability for your own use and consumption through any sources, other than by prescription or order of a licensed physician or other healthcare provider authorized to prescribe?	_____	_____
16.	Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice as a radiologist assistant with reasonable skill and safety to patients?	_____	_____
17.	If your answer to any one of the three preceding questions is "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 engaging in illegal use of controlled substances or other drugs having addiction-forming or addiction-sustaining liability?	_____	_____
18.	During any radiologist assistant training were you ever on probation, restrictions, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)?	_____	_____
19.	Have you ever been diagnosed as having, or have you ever been treated for, pedophilia, exhibitionism or voyeurism, bipolar disorder, sexual disorder, schizophrenia, paranoia or other psychiatric disorder?	_____	_____
20.	Have you ever had a judgement rendered against you, a judgement pending against you or action settled relating to the performance of your professional service?	_____	_____
21.	Have you ever been denied medical malpractice liability insurance?	_____	_____
22.	To your knowledge, have you ever been or are you now, the subject of an investigation or disciplinary proceeding by any licensing board/agency as of the date of this application?	_____	_____
23.	Have you ever been arrested, other than minor traffic citations?	_____	_____

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.

24. Have you ever applied for, or been denied a Mississippi radiologist assistant license? _____

25. Military Service, Branch (if applicable) _____ Dates_____

26. Anticipated date to begin practice as a radiologist assistant in Mississippi _____

I. PRACTICE NAME AND PRACTICE LOCATIONS

List name as appears at each current practice location. Number 1 should be your "Current" practice location (where you spend the majority of your practice time.) Number 2 should be your "Intended" Mississippi practice location. Numbers 3 & 4 may be used for additional practice locations.

	Practice Name	Address	City, State, Zip
1.			
2.			
3.			
4.			

II. BACCALAUREATE/MASTERS DEGREE

List dates/name/address of the school(s) where Baccalaureate and/or Masters degree was received. Request copy of education transcript be sent directly to the Mississippi Medical Board.

		Name of School	City/State
1.	From_____ to_____		
2.	From_____ to_____		
3.	From_____ to_____		

III. RADIOLOGIST ASSISTANT EDUCATION

List dates/name/address of the school(s) where radiologist assistant education was received. Request copy of education transcript be sent directly to the Mississippi Medical Board.

		Name of School	City/State
1.	From_____ to_____		
2.	From_____ to_____		
3.	From_____ to_____		

IV. REFERENCES

List two radiologists (other than family members) licensed in the United States or Canada with whom you have worked or trained within the last two years. Two radiologists must be listed with complete addresses. All incomplete applications will be returned.

	Physician Name	Street or P.O. Box	City, State & Zip
_____	1.		
_____	2.		

V. ACTIVITIES FOLLOWING RADIOLOGIST ASSISTANT EDUCATION

List all practice experience in chronological order since completion of your formal training giving dates, institutions/hospitals, and complete addresses. If any period did not include practice experience, give explanation. All activities following radiologist assistant education must be accounted for. Use separate sheet if necessary.

		Place	Address
_____	1. From _____ to_____	_____	_____
			_____
_____	2. From _____ to_____	_____	_____
			_____
_____	3. From _____ to_____	_____	_____
			_____
_____	4. From _____ to_____	_____	_____
			_____
_____	5. From _____ to_____	_____	_____
			_____

VI. HOSPITAL PRIVILEGES

List all hospitals in chronological order where you have held staff privileges as a radiologist assistant. Use a separate sheet if necessary.

		Place	Address
_____	1. From _____ to_____	_____	_____
			_____
_____	2. From _____ to_____	_____	_____
			_____
_____	3. From _____ to_____	_____	_____
			_____
_____	4. From _____ to_____	_____	_____
			_____
_____	5. From _____ to_____	_____	_____
			_____

VII. STATE LICENSURE

List all states where you have been licensed to practice as a radiologist assistant or have applied for a license to practice as a radiologist assistant. Include limited, restricted, temporary, educational or training licenses. It is a requirement that each state complete one of the verification forms included with your application.

License Number	State	Year Issued	License Number	State	Year Issued

VIII. ARRT EXAMINATION

		Date	Score
1.	Examination		

IX. MEDICAL MALPRACTICE INSURANCE

List names and addresses of insurance carriers from whom you have obtained medical malpractice liability insurance.

		Name	Address
	1.		
	2.		

PHOTOGRAPH
(wallet-size, passport-type)
TAKEN WITHIN
SIXTY (60) DAYS

must be attached here with tape. Do not paste.

COMPUTER GENERATED OR

INFORMAL SNAPSHOTS

WILL NOT BE ACCEPTED

X. AFFIDAVIT AND RELEASE

I, _____, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of any license to practice as a radiologist assistant granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Mississippi State Board of Medical Licensure from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Mississippi State Board of Medical Licensure and release this person or organization from any liability for the release of information.

Date _____ _____

Applicant's Signature

County of _____

State of _____

SWORN to and subscribed before me this _____ **day of** _____**, in the year**

of _____**.**

(SEAL) _____

Notary Public

My Commission Expires: _____

FOR USE OF MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE ONLY

Supervising Physician: _____

Date Protocol Approved: _____

Date License Issued: _____

License Number: _____