STATE OF NEW HAMPSHIRE OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
MEDICAL IMAGING AND RADIATION THERAPY
7 Eagle Square, Concord NH 03301
603-271-2152

APPLICATION FOR REINSTATEMENT OF LICENSURE

If a question does not apply to you mark the space with N/A. This includes but is not limited to "maiden & aliases" and your "Place of employment."

What profession are you applying for? _____

Name:_____
last first middle initial maiden & aliases

_____
Home physical address (Street #, City, State and Zip)

Home phone # or personal cell phone #: _____

_____
Home mailing address (Street # or P.O. Box #, City, State and Zip)

_____
Place of employment name (if any)

_____
Place of employment mailing address (Street # or P.O. Box #, City, State and Zip)

Place of employment phone #: _____

If you answer Yes to any of the 4 questions below, attach a detailed report of the relevant circumstances on a separate sheet. Have you:

	Yes	**No**
Been found guilty or entered a plea of no contest to any felony or misdemeanor?	_____	_____
Been the subject of any disciplinary action by any professional licensing authority?	_____	_____
Been denied a license, or other authorization to practice in any state or jurisdiction?	_____	_____
Surrendered a license or other authorization to practice in order to avoid or settle Disciplinary charges?	_____	_____

PLEASE DO NOT WRITE BELOW THIS LINE

FOR OFFICE USE ONLY: Date received_____ check #_____ amount _____

License/Certificate # _____

E-mail address at which you wish to receive correspondence: _____

Other State(s) licensing information: List all states or other jurisdictions in which you are currently or have previously been licensed to practice, enclose additional sheet if necessary:

STATE:	DATE LICENSE WAS HELD	IS LICENSE CURRENT?	IF EXPIRED, REASON

Which of the addresses listed can the Board make available to various public entities? (Choose only one)

Home mailing address: ☐ Place of Employment Mailing Address: ☐ None: ☐

	Yes	No
Do you have any reason to believe that you will soon be the subject of a disciplinary proceeding, settlement agreement or consent decree undertaken or issued by a professional licensing board of any state or jurisdiction?	_____	_____
Has any malpractice claim been made against you?	_____	_____
Have you, for disciplinary reasons, been put on administrative leave or had any privileges limited, suspended or revoked from any of the following settings: hospital, healthcare institution or setting, home health care agency or educational institution?	_____	_____
Have you ever been denied the privilege of taking an examination required for professional licensure?	_____	_____
Have you any physical, mental or emotional condition, or an alcohol or substance abuse problem, which could negatively affect your ability to practice the profession for which you seek licensure?	_____	_____
Do you engage in any remedial undertaking to alleviate any of the conditions listed in the Question above which could itself negatively affect your ability to practice the profession for which you seek licensure?	_____	_____
Have you committed any act(s) that would violate the laws and/or rules that govern the profession for which you are applying?	_____	_____

NOTE…If the answer to any of the 6 questions listed above are "yes", please attach a detailed report of the relevant circumstance on a separate sheet.

Personal Affidavit

Attach photocopy of
National certification card

in this

space

I acknowledge that knowingly making a false statement on this application form is a misdemeanor under RSA 641:2, I. I certify that the information I have provided on all parts of the application form and in the documents that I have personally submitted to support my application is complete and accurate to the best of my knowledge and belief. I also certify that I have read the statute and the rules of the Board and promise that, if I am licensed, I will abide by them.

I certify that I have not engaged in medical imaging or radiation therapy in New Hampshire on volunteer or paid basis since the date that my license ceased to be valid.

Applicant's printed name

Applicant's Signature

Date

BOARD ACTION SIGN OFF PAGE

FAST TRACK REINSTATEMENT LICENSURE OR CERTIFICATION APPROVAL:

☐ Not Eligible

Approved: _____ Date: _____

Ratified: _____ Date: _____

BOARD APPROVAL FOR REINSTATEMENT OR CERTIFICATION APPROVAL:

☐ Not Applicable

Approved: _____ Date: _____

BOARD APPROVAL FOR CONDITIONAL REINSTATEMENT:

☐ Not Applicable

Approved: _____ Date: _____

Conditions: _____

_____

_____

_____

_____

_____

_____