

STATE OF NEW HAMPSHIRE OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
BOARD OF MEDICAL IMAGING AND RADIATION THERAPY

7 Eagle Square, Concord NH 03301
603-271-8380 Fax 603-271-6702

APPLICATION FOR INITIAL LICENSURE

Fee: \$110.00

Make check payable to: Treasurer, State of NH

**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 #: _____

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

Date of Birth: _____ **Place of Birth:** _____
(City and State)

FOR OFFICE USE ONLY: Date received _____ **check #** _____ **amount** _____

License/Certificate # _____ Provisional # _____

NOTE... If the answer to any of the following 6 questions is "yes", please attach a detailed report of the relevant circumstance on a separate sheet.

	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, been fired for cause other than staff reductions from a position at your place of employment, or had any privileges limited, suspended or revoked in any of the following settings: hospital, healthcare setting, home health care agency, educational institution, or other professional settings.	_____	_____
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?	_____	_____

Social Security Number

The Governing Board of your profession will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public.

The Board is required to obtain your social security number for the purpose of child support enforcement in compliance with 42 USC 666(a)(13) and RSA 161-B:11. This collection of your social security number is mandatory.

Social Security Number

Undergraduate and Graduate Education

College/University/Other Institution	City/State	Degree	Year	Major
Undergrad: _____				
Graduate: _____				

List jurisdictions where you are, or have ever been, licensed or certified to practice _____

HAVE YOU:

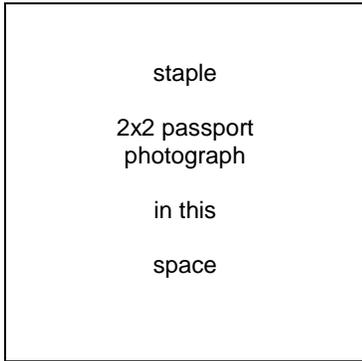
	Yes	No
Ever been found guilty or entered a plea of no contest to any felony or misdemeanor?	_____	_____
Ever been the subject of any disciplinary action by any professional licensing authority?	_____	_____
Ever been denied a license, or other authorization to practice in any state or jurisdiction?	_____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

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

	Yes	No
Pursuant to RSA 125:25-C do you have an ownership interest in any diagnostic or therapeutic service(s) company(ies)? <u>If you answer "yes" you must attach a list of ALL diagnostic or therapeutic services provided by each company.</u>	_____	_____

NOTARIZATION PAGE

Personal Affidavit



State of _____

County or City of _____

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.

Applicant's printed name

Applicant's Signature

Date

Sworn to before me and subscribed in my presence this _____ day of _____, 20____.

Notary Public / Justice of the Peace

My commission expires

(Seal or stamp)

BOARD ACTION SIGN OFF PAGE

FAST TRACK FULL LICENSURE APPROVAL:

Approved: _____ Date: _____

Ratified: _____ Date: _____

BOARD APPROVAL FOR INITIAL LICENSURE:

Approved: _____ Date: _____

BOARD APPROVAL FOR PROVISIONAL LICENSURE:

Approved: _____ Date: _____

BOARD APPROVAL FOR CONDITIONAL LICENSURE:

Approved: _____ Date: _____

Conditions: _____

