



Radiation Control Program Mammographer Certificate of Authorization Application



APPLICANT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	
NAME ON RADIOGRAPHER CREDENTIAL ¹			
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER	E-MAIL	
NAME OF CURRENT EMPLOYER	EMPLOYER'S ADDRESS		PHONE NUMBER

- Submit certified copy of current and valid general radiographer credentials.
- Submit proof of advanced training in mammography, as required by NAC 457.350. ²
- Submit check payable to *Nevada State Health Division* in the amount of \$88.00 .

PERSONAL DATA	Y	N
1. Within the past 10 years, was your certificate or license suspended, revoked, restricted, or denied in any state, federal or foreign jurisdiction?		
2. Within the past 10 years, were you disciplined for unprofessional conduct such as patient abuse, incompetence, negligence, or unsafe practices?		
3. Within the past 10 years, were you convicted of a felony, or named in any past or pending civil suit alleging incompetence or negligence in the care of others?		
4. Are you presently afflicted by any medical condition which may impair your ability to practice with reasonable skill and safety?		

If **YES** to any of questions 1 through 4, submit an explanation with this application. ³

¹ If different, submit copy of marriage license, court decree, etc.

² Proof of training must include:

(a) 40 hours' training in mammography — must list hours of instruction in each subject; **or**

(b) Accreditation by recognized credentialing institution (*i.e.*, ARRT) or one approved by the Nevada Board of Health.

³ A **YES** answer does not necessarily preclude certification.

CHILD SUPPORT INFORMATION ⁴

I am **NOT** subject to a court order for the support of a child.

I am subject to a court order for the support of one or more children and am in compliance with the order, or am in compliance with a plan approved by the district attorney (or other public agency enforcing the order for the repayment of the amount owed pursuant to the order); or

I am subject to a court order for the support of one or more children and am **NOT** in compliance with the order or plan approved by the district attorney (or other public agency enforcing the order for the repayment of the amount owed pursuant to the order).

ATTESTATION

I, _____, attest that I am the person described and identified in this application; that I have answered all questions in this application truthfully and completely; that the furnished supporting documentation is accurate to the best of my knowledge. I understand that prior to making a determination regarding my application; the Health Division may require additional information from me.

SOCIAL SECURITY NUMBER

SIGNATURE

DATE

⁴ This application cannot be processed until the applicant checks the appropriate box.