

MARYLAND BOARD OF PHYSICIANS

P. O. BOX 37217
BALTIMORE MARYLAND 21297
(410)764-4777
1-800-492-6836
www.mbp.state.md.us

TTY FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258

APPLICATION FOR REINSTATEMENT OF RADIATION THERAPISTS, RADIOGRAPHERS, OR NUCLEAR MEDICINE TECHNOLOGISTS

INSTRUCTIONS AND IMPORTANT INFORMATION

- 1. Fee:** The fee for reinstatement is **\$150.00**. Checks and/or money orders should be made payable to the Maryland Board of Physicians. **The application fee is not refundable.** (Please note that without the required fee, your application will be returned to you.)
- 2. Mailing Instructions:** Mail your completed application, appropriate fee and supporting documentation to the address at the top of this page (P.O. Box 37217, Baltimore, MD 21297). DO NOT mail or hand deliver your application to the Board office. Any application that is mailed or hand delivered to the Board office will be forwarded to the post office box at the top of the application within 24 - 48 hours. This will delay the processing of your application. **FYI - Federal Express (FEDEX) or UPS does not deliver to post office boxes.**
- 3. Processing time:** Generally, the application process takes approximately 2 - 4 weeks. However, the process may take longer depending on the individual applicant's circumstances or if the individual does not provide the required documentation on a timely basis.

Please do not **continuously** call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days **from the receipt** of your application, your analyst will mail a letter to you requesting additional documentation if additional documentation is required.

If you have met all the requirements for certification, your analyst will generally issue a license within 3-5 business days **from the receipt** of your application. Once the certificate has been reinstated, you should be able to check it on the Board's website at www.mbp.state.md.us. *The website is updated every 24 hours.*

PRIOR TO CONTACTING YOUR ANALYST, PLEASE CHECK THE BOARD'S WEBSITE TO DETERMINE IF YOU HAVE BEEN ISSUED A LICENSE. Click Search Practitioner Profiles; then enter your last name into the appropriate field.

- 4. Application:** Complete all questions on the application. Answer the **Character and Fitness questions** "YES" or "NO." If you answered "YES" to any item, **please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge. Incomplete applications will delay the review process.**

The Board will keep your application open for 120 days from the original date of receipt. All requirements for reinstatement must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

- 5. Name:** If the name on the application form differs from the name on your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

INSTRUCTIONS AND IMPORTANT INFORMATION (Continued)

6. **Address:** The non-public (home) address will be the location to which the Board directs all correspondence. The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

7. **Date of Birth and Sex:** This information is not a requirement for reinstatement of certification, but the information provided will be used for identification purposes and criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for their professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

- A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
- B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
- C. Identification by the Department of Assessments and Taxation of new businesses in Maryland Health Occupations Article, §1-210);
- D. Verification of payment of undisputed Maryland taxes or Unemployment Insurance Contributions (Chapter 203, Acts 2003; Health Occupations §1-213);
- E. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

9. **Licensure in Other States:** If you ever have been licensed/certified/registered to practice radiation therapy, radiography, or nuclear medicine technology or if you ever have been licensed/certified/registered to practice ANY other health profession in any other state, including Maryland, complete the top portion of the **Verification of Other State License(s)** form and send it to the licensing board or agency in each state in which you have ever been licensed/certified/registered. This form may be duplicated as many times as necessary.

10. **Continuing Education:** For the two-year period immediately preceding the submission of the application for reinstatement, you must submit documentation of one of the following:

- a. Verification of current American Registry of Radiologic Technologist (ARRT) certification; OR
- b. Documentation of 24 hours of approved continuing education; OR
- c. Documentation of achieving a passing score on a relevant examination not more than 3 months before making an application. (Example: ARRT Reinstatement by Re-Examination).
- d. Active certification by the Nuclear Medicine Technology Certification Board.

11. **Affirmation and Information Releases:** Please read and sign the Affirmation and Authorization of Release of Information. Please also sign the Optional Third Party Release if you plan to use an intermediary to receive information about the status of your application.

12. **Practicing Without a License:** You may not practice radiation therapy, radiography, or nuclear medicine technology Maryland until you receive written notification from the Board that your certification has been reinstated. You may not provide, attempt to provide, offer to provide, or represent to the public that you are practicing as radiation therapy, radiography, or nuclear medicine technology unless your license has been reinstated. Health Occupations Articles §§14-5B-17 and 14-5B-18, Annotated Code of Maryland.

13. **Expiration and Renewal:** Regardless of the date your certification is reinstated, it will expire April 30 of the first odd year following reinstatement. Approximately 30 - 60 days prior to expiration, you should receive a notice to renew your certification. The renewal notice will be mailed to the current address on file with the Board. ***You will be required to renew by April 30 of the odd year whether or not you receive the renewal notice.***

The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board ADA designee, Ellen Douglas Smith at (410)764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Smith.



Maryland Board of Physicians

Check One:

Initial Licensure

Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

“Veteran” means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.

“Veteran” does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.

“Military Spouse” means the spouse of a service member or veteran,

“Service Member” means an individual who is an active duty member of:

“Military Spouse” includes a surviving spouse of:

- * A veteran; or
- * A service member who died within one year before the date on which the application for license, certification, or registration is submitted.

- * The Armed Forces of The United States
- * A reserve component of the Armed Forces of the United States; or
- * The National Guards of any state

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

- Service Member – Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation..**
- Veteran – Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**
- Military Spouse: **Check the appropriate box**
 - Spouse is a Veteran. **Provide supporting documentation.**
 - Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
 - Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

Name of Applicant (PRINT)

Military Branch

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FOR BANK USE ONLY	
DATE:	____/____/200____
CHECK NUMBER:	_____
AMT PAID: \$	_____
NAME CODE:	_____
APPID: 11	

FOR BOARD USE ONLY

Reinstatement Date: _____

**APPLICATION FOR REINSTATEMENT OF
OF RADIATION THERAPISTS, RADIOGRAPHERS, OR NUCLEAR
MEDICINE TECHNOLOGISTS**

Fee: \$150.00

TYPE OR PRINT:

Maryland License Number: _____

Date Expired: ____/____/____

1. Full Legal Name

Last Name and Generational Indicator (Jr., III, etc.) First Name Middle Name Maiden Name

2a. Non-Public Address: (This address, usually your home, is for correspondence between you and the Board. However, if no public address is listed, this address will be made available to public. Do NOT use a P.O. Box. If you change your address prior to being licensed, immediately notify the Board in writing.)

Street Name and Number APT

City State Zip Code

2b. Public Address: (Your public address of record. This address, usually your office, is available to the public and may be posted on the internet. If you change your address prior to being licensed, immediately notify the Board in writing.)

Facility Name

Street Name and Number

City State Zip Code

3a. Telephone - Home: (____) _____ - _____

3b. Work: (____) _____ - _____

4. E-mail address: _____

5. Sex: ____ Male ____ Female

6. Social Security No. _____ - _____ - _____

7. Date of Birth: _____ - _____ - _____
MM DD YYYY

8. Professional School of Graduation _____

9. Location (City/State) of Professional School: _____

10. Date of Graduation _____

11. Continuing Education Requirement: Check ONE of the following and attach documentation to this application.

- a. _____ Verification of current ARRT certification. **(If you are on CE Probation, you will need to provide 24 hours of approved continuing education hours.)**
- b. _____ Documentation of 24 hours of approved continuing education earned within the last 2 years.
- c. _____ Documentation of a passing score on a relevant examination. (Example: ARRT Reinstatement by Re-Examination)
- d. _____ Active certification by the Nuclear Medicine Technology Certification Board.

12a. Verification of Licensure as a Radiation Therapist, Radiographer, or Nuclear Medicine Technologist. List all states or other jurisdictions in which you hold or have held registration/certification/licensure to practice Radiography, Radiation Therapy, Nuclear Medicine Technology. Please complete and mail the attached **Verification of Other State License(s)** form to the appropriate State Board(s). If you have never been registered, certified, or licensed, **please write N/A below.** (Use additional sheets, if necessary)

STATE	REGISTRATION/LICENSE#	CATEGORY (R.T.(R), R.N., Etc.)	YEAR ISSUED	EXPIRATION DATE

12b. Verification of Licensure as a health care professional other than a Radiation Therapist, Radiographer, or Nuclear Medicine Technologist. List all states or other jurisdictions, including Maryland, in which you have ever held a license/certification/registration to practice in ANY other health occupation. Be sure to complete and mail the attached **Verification of Other State License(s)** form to the appropriate State Board(s). If you have never been registered, certified, or licensed, **please write N/A below.** (Use additional sheets, if necessary)

STATE	REGISTRATION/LICENSE#	CATEGORY (R.T.(R), R.N., Etc.)	YEAR ISSUED	EXPIRATION DATE

CHARACTER AND FITNESS QUESTIONS

13. Answer **YES**” or **NO**” to the following items. If you answered **“YES**” to any question, on a separate sheet of paper, please provide a detailed explanation and attach any supporting documents. Examples of documentation is next to the question. Please note that these examples are not all inclusive. **Failure to provide documentation and an explanation will delay the processing of your application. These questions apply to the period since your last registration in Maryland.**

Since your last renewal:

- _____ A. Have you been denied a license, certification or registration to practice any health occupation? **(e.g. state board orders and/or charges; adverse or disciplinary actions in any healthcare facility)**
- _____ B. Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? **(e.g. state board orders and/or charges; adverse or disciplinary actions)**
- _____ C. Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? **(e.g. state board orders and/or charges; adverse or disciplinary actions)**
- _____ D. Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? **(e.g. provide name of institution, correspondence received or sent, related documents.)**
- _____ E. Have you ever been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? **(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**
- _____ F. Have you been convicted or received probation before judgment for driving while intoxicated or impaired? **(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**
- _____ G. Do you currently have a physical or mental condition which may affect your ability to practice your profession? **(e.g. medical evaluations)**
- _____ H. Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? **(e.g. malpractice claims)**
- _____ I. Have you ever been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, type of discharge. **(e.g. DD214)**
- _____ J. Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? **(e.g. copy of charges)**

14. RADIATION THERAPISTS, RADIOGRAPHERS AND NUCLEAR MEDICINE TECHNOLOGISTS

Beginning with the most recent, describe your employment history since your last renewal. Explain any lapsed time over 1 year in which you did not practice as a Radiation Therapist/Radiographer/Nuclear Medicine Technologist or in another health field. Please make additional copies as needed.

Length of Employment	1) Name of Employer 2) Address of Employer 3) City, State, Zip Code 4) Supervisor	Position
Month and Year		Phone Number
From	1)	
	2)	
To	3)	
	4)	
From	1)	
	2)	
To	3)	
	4)	
From	1)	
	2)	
To	3)	
	4)	
From	1)	
	2)	
To	3)	
	4)	

15. List reasons for allowing the Maryland Radiation Therapist, Radiographer, or Nuclear Medicine Technologist license to expire:

16. List reasons for seeking reinstatement of the Maryland Radiation Therapist, Radiographer, or Nuclear Medicine Technologist license:

17. AFFIRMATION:

I affirm that the information I have given in this application is true and correct and that I am thoroughly familiar with the Maryland Statute (Health Occupations Article §14-5B-01 et seq.) and Regulations (COMAR 10.32.10) which govern the practice of Radiation Therapy, Radiography, and Nuclear Medicine Technology. I also understand that any false information provided as part of my application may be cause for denial of my application.

Name in print

Signature

Date

18. AUTHORIZATION OF RELEASE OF INFORMATION:

I authorize the Maryland Board of Physicians (the Board) and the Radiation Therapy, Radiography Nuclear Medicine Technology and Radiologist Assistance Advisory Committee to request any information necessary, including personnel records, to process my application for Radiation Therapy, Radiography and Nuclear Medicine Technology in Maryland from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Name in print

Signature

Date

19. (OPTIONAL) Third Party Release: (If you plan to use an intermediary to receive information about the status of your application, please complete the release.)

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following persons:

Name of person to whom the information can be released

Date

Phone number of person to whom information can be released

Applicant's Signature

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VERIFICATION OF OTHER STATE LICENSES

**RADIATION THERAPISTS/RADIOGRAPHERS/NUCLEAR MEDICINE TECHNOLOGISTS
REINSTATEMENT APPLICATION**

APPLICANT: Please: (1) Complete and sign **Part 1** of this form and mail it to each State Board that ever issued you a certification, license or registration to practice Radiation Therapy, Radiography or Nuclear Medical Technology; (2) Send this form to any State Board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other allied health professional. Contact the state(s) to which you are sending this form to request fee information. Please copy this verification request if you need to send it to more than one state board.

PART 1:

Name and Location of State Board: _____

Name: _____
(Print) Last Name First Name Middle Name Maiden Name

Date of Birth: _____ Social Security Number: _____

Certification/license/registration number: _____ Date issued: _____ Expiration Date: _____

Professional School of Graduation: _____ Year: _____

Signature: _____ Date: _____

TO BE COMPLETED BY STATE BOARD: Authorized Official: Please complete **Part 2** for the above individual and send this form directly to the Maryland Board of Physicians at the above address.

PART 2:

Certification/license/registration number: _____ Date issued: _____ Expiration Date: _____

Is license/certification/registration in good standing? _____ Not in good standing? _____

If not in good standing was it: revoked _____ suspended _____ surrendered _____ reprimanded _____

Other Derogatory Information or Pending Charges: _____

Printed Name of Authorized Official: _____ Title: _____

Signature of Authorized Official: _____ Date: _____

Telephone Number, including area code: _____

Board Seal