OFFICE OF PROFESSIONAL REGULATION
VERMONT SECRETARY OF STATE
89 Main Street, 3rd Floor, Montpelier, VT 05620
802-828-1505 | sos.vermont.gov/opr

# Radiologic Technologist Verification of Licensure

**Official documentation can be sent by postal mail or by email to SOS.OPRLicensing2@vermont.gov.**

Applicant completes the top section of this form and the state or jurisdiction of **original licensure and your most current** state or jurisdiction of licensure completes the bottom portion. This form must be submitted directly to the office by the state completing.

**Applicant Information**

Applicant Name _____

Applicant Address _____

Date of Birth _____ License/Certificate # _____

Applicant's Signature _____ Date _____

**TO BE COMPLETED BY THE STATE OR JURISDICTION'S LICENSING AUTHORITY:** The Licensing Authority must send this form directly to the Board.

Certificate/License # _____ Date Issued _____

**Basis of Licensure**: ___Examination ___ Endorsement/Reciprocity_____(from)

___ Waiver on the basis of _____

**Status of License:** ___Active ___ Inactive ___ Lapsed

**Expiration Date of License:** _____

**Primary Certification:** ___Radiography ___ Radiation Therapy ___ Nuclear Medicine

**Post Primary Certification:** ___ M-Mammography ___ CT-Computed Tomography

___ CI-Cardiac-Interventional Radiography ___ VI-Vascular-Interventional Radiography

VERMONT SECRETARY OF STATE

Does your jurisdiction require successful completion of the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) examination for the specialty in which licensed? YES NO

**Disciplinary Action:**

Has the license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way or is it currently under investigation?

YES NO

If YES, please attach a copy of the decision.

Printed name and title of Authorized Agent _____

Signature of Authorized Agent _____

State completing form _____ Date _____

(affix seal here)