

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE RADIOLOGY. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a license to practice radiology/limited permit in the State of Montana and the Board of Radiologic Technologists requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF RADIOLOGIC TECHNOLOGISTS, PO BOX 200513, HELENA, MT 59620-0513**. Your early response is appreciated.

(Signature)

Name (Please Print)

Address _____

My License Number is _____

DO NOT DETACH - - THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF RADIOLOGIC TECHNOLOGISTS.

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

Licensed by Examination _____ Endorsement (List State) _____ Other (Please List) _____

License is Current? Yes No If NO, explain _____ License Status Active Inactive Other

Has License been suspended, revoked, on probation or otherwise disciplined? If YES, explain and attach documentation. Yes No

Has licensee ever been requested to appear before your Board? If YES, explain. Yes No

Derogatory information, if any _____

Comments, if any _____

BOARD SEAL

Signed: _____

Title: _____

State Board: _____

Date: _____