STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS AN OSTEOPATHIC X-RAY OPERATOR

Documents needed from all applicants

1. Notarized and completed application. Please be advised that all 6 pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead to attest to good moral character. The letters must contain original signatures.
3. Attachment 2 - Clearance from other state X-Ray Certification Boards (Required only if licensed in other states)
4. Fees. See page one of the application. Please note all fees are non-refundable.
5. Submit a clear, recognizable, recently taken bust photograph which shows the full head, face forward from at least the top of the shoulder up.
6. Criminal Background Check. Click here for instructions.
7. Complete attachment 5 – Declaration of Citizenship

Full certification documentation

1. Items 1 through 7 above.
2. Notarized copy of A.R.R.T. or ARCRT certification card.
3. Submit notarized copy of high school diploma or GED.

Limited certification documentation needed

1. Items 1 through 7 above.
2. Notarized copy of high school diploma or GED certificate.
3. Verification of successful completion of a Board approved training course.
4. Attachment 1 - Physician's Statement of Clinical Experience (This form must be completed by a licensed osteopathic physician and bear original signature)
5. Verification of passing test scores on the A.R.R.T. Limited Scope Exam

Bone densitometry certification documentation

1. Items 1 through 7 above.
2. Notarized copy of high school diploma or GED certificate.
3. Verification of successful completion of a Board approved training course.
4. Attachment 4 must be completed by the manufacturer or its authorized representative. (Must be sent directly to the Board from the manufacturer or its authorized representative.)
5. Provide proof of having successfully completed the A.R.R.T.'s Limited Bone Densitometry Equipment Operators Examination.

Upgrade certification documentation

1. Items 1, 3, 4, and 5 above.
2. Attachment 1 - Physician's Statement of Clinical Experience (This form must be completed by a licensed osteopathic physician and bear original signature)
3. Attachment 3 - Upgrade Certification Form (This form must be completed by the program director of the Board approved training program attended)
4. Verification of passing test scores on the A.R.R.T. Limited Scope Exam
5. Original X-Ray Certificate issued by the Tennessee Board of Osteopathic Examiners

UNDERSTANDING THE APPLICATION PROCESS

1. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Tennessee Board of Osteopathic Examination
ATTN: X-Ray Operators
665 Mainstream Drive
Nashville, TN 37243

2. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

3. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. Files not completed within ninety (90) days will be closed.

4. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination. Application approval may also be accessed through our webpage at www.tennessee.gov and click on licensure verification.

5. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.

6. It is recommended that you do not make arrangements to accept employment as a x-ray operator in Tennessee until you are granted a license number by the Board of Medical Examiners.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

For Official Use Only

Limited	1944-001	$ 50.00
	1944-006	$ 10.00
Full	1944-001	$ 50.00
	1944-006	$ 10.00

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APPLICATION FOR LICENSE AS AN OSTEOPATHIC X-RAY OPERATOR

Name _____
(First) (Middle and/or Maiden) (Last)

Date of Birth _____ Social Security # _____
(Month) (Day) (Year)

Current Home Mailing Address

_____
_____
_____

Current Practice Address

_____
_____
_____

Home Phone ( ) _____ Work Phone ( ) _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

Please indicate the type of license for which you are applying, and enclose the appropriate fee. Your check or money order should be made payable to the State of Tennessee.

_____ FULL CERTIFICATION **(FEE OF $50.00 PLUS $10.00 STATE REGULATORY FEE) MUST BE ARRT CERTIFIED.**

_____ LIMITED CERTIFICATE (specify qualification)
(FEE OF $50.00 PLUS $10.00 STATE REGULATORY FEE)

_____ Chest
_____ Extremities
_____ Sinuses
_____ Skull (AP/PA and Lateral Skull Only)
_____ Spine
_____ Bone Densitometry

_____ UPGRADE LIMITED CERTIFICATION: State Certification Number: _____
(FEE OF $50.00 PLUS $10.00 STATE REGULATORY FEE)

_____ Chest
_____ Extremities
_____ Sinuses
_____ Skull (AP/PA and Lateral Skull Only)
_____ Spine
_____ Bone Densitometry

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for your attendance in high school. Use the back of this page if you need

additional space. (ATTACH COPY OF YOUR HIGH SCHOOL DIPLOMA OR GED CERTIFICATE IF APPLICABLE.)

From:_______ To: _______ ______________________________ ____________________________
Mo/Yr Mo/Yr Educational Institution/High School Location

Please complete your entire employment history starting with the most current position first. Use the back of <u>this page</u> if you need additional space.

DATES	LOCATION	POSITION AND DUTIES
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________
From:_______ To: _______ Mo/Yr Mo/Yr	______________________ (City) (State)	______________________

CERTIFICATION INFORMATION

List below ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED as an Osteopathic X-Ray Operator. Additional pages may be added if necessary. Submit a copy of Attachment 2 to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below ALL states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than an Osteopathic X-Ray Operator. Additional pages may be added if necessary. Submit a copy of Attachment 2 to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, and to learn and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____

[*If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

COMPETENCY INFORMATION CONTINUED

QUESTIONS	Yes	No
2. Do you currently use chemical substances as defined on page 4?	____	____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
Please list: _____		
3. Are you currently engaged in the illegal use of controlled substances?	____	____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5. If you have ever held or applied for a license or certificate to practice as a x-ray operator in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
8. Have you ever been rejected or censured by a professional society?	____	____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	____	____
b. Have you ever had settlement of any legal action rendered against you; or	____	____
c. Are there any legal actions pending against you or to which you are a party?	____	____
10. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) (City) (State)
being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice as a x-ray operator in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a x-ray operator.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications:

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires:_____

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

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Physician's Statement of Clinical Experience
(NOT REQUIRED FOR FULL CERTIFICATION)

This form must be completed and signed by the supervising physician. This form must bear the original signature of the supervising physician.

Name of Applicant: _____

Social Security Number: _____

I hereby certify that the above named X-Ray Operator has obtained clinical training as required in rules and regulations 1050-3-.07(2)(c). Please indicate the number of supervised hours in each of the qualifications that apply.

Sixty (60) hours is required for each qualification sought:

# of Hours	Qualifications
_____	Chest
_____	Extremities
_____	Sinuses
_____	Skull (AP/PA and Lateral Skull Only)
_____	Spine

Please make a brief statement regarding the professional competence of this applicant:

_____

_____

_____

_____ _____
Physician's Name (Please Print) License Number

_____ _____
Date Physician's Signature

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
OSTEOPATHIC X-RAY OPERATOR
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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

Please complete the top portion of this form and forward it to the regulatory board in each state where you hold or have held a license to practice any profession. (This form may be duplicated.)

NOTE: Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

****

I was granted a license or certificate to practice _____ numbered _____ on _____ by the State of _____.
Lic. #
Date

The Tennessee Board of Medical Examiners request that I submit evidence that my certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to: Tennessee Board of Osteopathic Examination, Attn: X-Ray Operators, 665 Mainstream Drive, Nashville, TN 37243.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

****

THIS PORTION IS TO BE COMPLETED BY STATE REGULATORY BOARD

License Number: _____ Date Issued: _____
Profession: _____
Basis of Issuance: Endorsement/Reciprocity With: _____
Written Examination: _____
(Provide Description of Exam)

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No
If "yes", please attach explanation.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
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Certification Upgrade

This form must be completed by the Director of a Board approved radiological education course and submitted directly to the Tennessee Board of Medical Examiners.

Name of Applicant: _____

SSN#: _____

State Certification Number: _____

Board Approved Course: _____

Address: _____

_____

The above named applicant has been instructed in the above Board approved course and completed the additional clock hours required to upgrade his/her Medical X-Ray Operator Certification in the following qualification: **(Please indicate the hours completed by each qualification.)**

_____ Chest
_____ Extremities
_____ Sinuses
_____ Skull (AP/PA and Lateral Skull Only)
_____ Spine
_____ Bone Densitometry

Date Training Completed: _____

_____
Signature of Director

_____
Date

ATTACHMENT 4

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
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665 MAINSTREAM DRIVE
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Manufacturer or its Authorized Representative Statement of Training
(NOT REQUIRED FOR FULL CERTIFICATION)

This form must be completed and signed, bearing the original signature, by the manufacturer or its authorized representative.

Name of Applicant: _____

Social Security Number: _____

I hereby certify that the above named X-Ray Operator has obtained training as required in rules and regulations 1050-3-.07(2)(c)2 pertaining to bone densitometry.

_____ Bone Densitometry

Please make a brief statement regarding the professional competence of this applicant:

_____

_____

_____

_____
Manufacturer/Representative (Please Print)

_____ _____
Date Manufacturer/Representative

ATTACHMENT 5

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every* ***adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.**

I am a(n) _____ _____.
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name:_____
Last First Middle Maiden_
2. Mailing Address: _____
_
3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:

   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)

   a) Permanent Residents

b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.