STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATIONS
DIVISION OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

(615) 741-5735 or (800) 778-4123, ext. 741-5735
https://www.tn.gov/health/health-program-areas/health-professional-boards/podiatric-board.html

APPLICATION INSTRUCTIONS
FOR CERTIFICATION AS AN X-RAY OPERATOR IN A PODIATRIST'S OFFICE

1. Complete this application and mail it to the above address.
2. Enclose a non-refundable check for $ 60.00, payable to the Board of Podiatric Medical Examiners.
3. Attach a recent passport type photograph to the front of this application.
4. Enclose proof of being at least eighteen (18) years of age.
5. Enclose proof of graduation from high school or its equivalent.
6. Enclose, or have submitted, official verification of successful completion of (60) hours of supervised clinical experience in radiographic methodology, technique, patient care and positioning, equipment maintenance, radiation protection and x-ray quality control.
7. You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.
8. Enclose, or have submitted an official verification of attendance and successful completion of six (6) contact hours of didactic classroom instruction in the field of x-ray operation. (See rules for sponsoring provider.)
8. If you are certified in another state(s) as an x-ray operator and or any other health professional, enclose a copy of the statutes and rules governing your practice in that state. Submit a current verification of active licensure/certification from the other state you reside in.
9. Examination Requirement – In order to be certified pursuant to this Chapter, the applicant must successfully complete an examination approved by the Board and shall achieve a minimum score of 70. **Note; Examination scores obtained by an applicant in order to apply for certification shall be effective for five (5) years from the date that the applicant took the examination or the last part of the examination, should the examination be given in multiple parts.**
10. For criminal background instructions go to: http://tn.gov/health/article/CBC-instructions. The "OCA" code for this profession is 2216.
11. All applicants must complete the Declaration of Citizenship form and have it notarized. The form may be found at: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf

2216-001 $ 25.00
2216-001 $ 25.00
2216-006 $ 10.00

Attach Photo Here

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APPLICATION FOR CERTIFICATION AS AN X-RAY OPERATOR IN A PODIATRIST'S OFFICE

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

Current Home Mailing Address

_____

_____

_____

Current Practice Name and Address

_____

_____

_____

Home Phone ( )_____

Work Phone ( )_____

Date of Birth _____
(Month) (Day) (Year)

Social Security # _____

U.S. CITIZEN: Yes_____ **No**_____ **Entitled to Live and Work in the U.S.: Yes** ___ **No** ____
All applicants must complete the attached Declaration of Citizenship form and have it notarized

Social Security Number: _____-_____-_____ **Date of Birth**: _____

E-Mail Address (personal): _____ **E-Mail Address (work)** _____
Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. **Yes** ____ **No** ____

Gender: Female _____ **Male** _____ **Race:** _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) **Yes** _____ **No** _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)
Yes __ **No** __

Have you ever been known by any other names besides what is listed above? **Yes** ____ **No** _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

List below states in which you hold a license as an X-Ray Operator or any health profession other than an X-Ray Operator (Request "Verification of Licensure" be sent directly to this board from each state in which you now hold or have ever held licensure.)

STATE LICENSED	PROFESSION/LICENSE NUMBER	DATE ISSUED

EDUCATION

	Date of Graduation	Major	Degree
High School			
Address			
GED			
Address			
College			
Address			

EMPLOYMENT INFORMATION

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	**Address:** (City, and State)	**Position:**	**Duties:**	**Dates From:** Mo./Yr.	**To:** Mo./Yr.

COMPETENCY QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. 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 diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical 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 professional 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 including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**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.

5. "**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.

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

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	____	____
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____

If so, please list: _____

[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 to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]

		YES	NO
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4.	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 illicit or controlled substances?	___	___
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice dentistry in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10.	Have you ever been rejected or censured by a professional association or society?	___	___
11.	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 entered into any settlement of any legal action; or	___	___
	c. Are there any legal actions pending against you or to which you are a party?	___	___
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT AND SIGN

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) *(City)* *(State)*

being identified as the person referred to in this application and signed photo, attest to the truth of each statement made in said application. I further attest that I have read and understand the law and the rules and regulations of the board and agree to abide by them when practicing as a podiatric 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 an 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 licensure.

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

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**

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PODIATRIST'S STATEMENT OF CLINICAL EXPERIENCE

This form must be completed and signed by the supervising podiatrist. This form must be mailed separately from the application and sent to the above address.

Name of Applicant:_____

I hereby certify that the above named x-ray operator has obtained sixty (60) hours of clinical training as required in Rule 1155-3-.02(2)(a). Please indicate the number of supervised hours in each of the qualifications that apply.

_____ training in radiographic methodology
_____ technique
_____ patient care and positioning
_____ equipment maintenance
_____ radiation protection
_____ x-ray quality control
_____ other (please describe)_____

_____

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

_____

_____

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

_____ _____
Podiatrist's Signature Date

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CLEARANCE FROM OTHER STATES OF LICENSURE/CERTIFICATION

I, the undersigned applicant, was granted a (circle one) license/certificate/permit to practice _____ with (check one) license/certificate/permit number _____ on _____ in the State of _____. The Tennessee Board of Examiners in Podiatry requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Podiatric Medical Examiners.

_____ _____
Applicant's Signature Date

_____
Applicant's Typed or Printed Name

****

TO BE COMPLETED BY ADMINISTRATIVE OF STATE CERTIFICATION BOARD

Name in full as it appears on license/certificate/permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Date of Expiration: _____
The license is currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____ If yes, Please attach supporting documentation

_____
Authorized Signature Title Date

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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

Name: _____
Last First Middle Maiden
Mailing Address: _____

Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)_____-_____

I am a United States Citizen: ____Yes ____No

Applicants Claiming United States Citizenship **MUST** provide one of the following:

1. Tennessee Driver's License, or photo ID issued by Department of Homeland Security.
2. A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Homeland Security criteria.
3. 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.
4. A federally issued birth certificate.
5. A valid, unexpired U.S. passport.
6. A report of birth abroad of a U.S. citizen.
7. A certificate of citizenship.
8. A certificate of naturalization.
9. A U.S. citizen ID card.
10. Any successor document to #'s 4-9 above.
11. SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

If you checked "No" please indicate from the list below which category applies to you:

_____ Permanent Residents

_____ 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.*).

_____ Foreign nationals not present in the United States seeking the issuance or renewal of a professional license.

_____ Asylees who meet the qualifications set out in 8 U.S.C. 1158

_____ Refugees who meet the qualifications set out in 8 U.S.C. 1157

_____ 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.

_____ Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980

_____ 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.

_____ 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**, please submit one or more 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:

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.