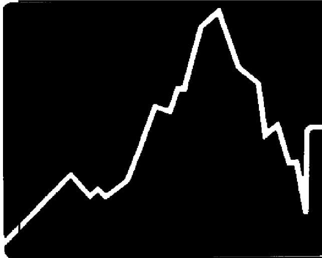
Print Name: ______________________________



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

FAX (804) 527-4426
(804) 367-3051

To Whom It May Concern:

The person listed below is applying for a license to practice as a radiologic technologist in the Commonwealth of Virginia. The Board of Medicine requests that the form be completed by each jurisdiction in which he/she holds or has held a license/certificate. Please complete the form and return it to the address below. Thank you.

Commonwealth of Virginia
Department of Health Professions
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

____
Name of Applicant (Please print or type.)

____
License/Certificate #

==

Name of Licensee ______________________________ State/Commonwealth of ______________________________

License/Certification number ________________________ Issued effective ______________________________

Licensed/certified through (check one)

☐ National Examination ☐ State Board Examination ☐ Reciprocity from (Name of State) ________________

License/certificate is: Current ☐ Lapsed ☐

Has the applicant's license/certificate ever been suspended or revoked? ☐ Yes ☐ No

If yes, for what reason?

____

Derogatory information, if any

____

Comments, if any

____

____

BOARD SEAL

Signed ______________________________________

Title ______________________________________

State Board ______________________________________

NOTE TO APPLICANT: PLEASE PROVIDE LICENSE NUMBER AND FORWARD TO STATE INDICATED