Certified Technologist, Nuclear Medicine Certificate Application

Last Name (Please Print)	First Name	Middle Name	
Date of Birth	SSN or ITIN*	Phone Number	
Mailing Address (Number and Street or P.O. Box Number)		Email Address	
City		State	Zip Code

*Social Security Number or Individual Taxpayer Identification Number

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the SSN/ITIN is mandatory. The SSN/ITIN will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. The information you provide on this form (except for SSN/ITIN) may be made public under the California Public Records Act; please provide a P.O. Box number or other alternate address if you do not wish to have your home address made public. This information may also be provided to the American Registry of Radiologic Technologists (ARRT) for examination purposes. For information or access to your records, contact the Certification Support Unit at the California Department of Public Health, Radiologic Health Branch (CDPH-RHB), MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

HOW DO I OBTAIN A CERTIFICATE AS A CERTIFIED TECHNOLOGIST, NUCLEAR MEDICINE?

Return the completed application together with the following documents:

- A copy of the ARRT (N) certificate for Nuclear Medicine, or
- A copy of the NMTCB certificate for Nuclear Medicine and a
- The non-refundable application fee of $228.00 in the form of a check (e.g., personal, cashier's, or certified check) or money order made payable to CDPH-RHB.

Notification of Application Status

Within 30 calendar days of receipt of your application, CDPH-RHB will mail you a notification letter. The notification letter will inform you of one of the following:

- That your application is complete *or*
- That your application is not accepted for filing and next steps.

Certified Technologist, Nuclear Medicine Certificate Application

Last Name (Please Print)	First Name	Middle Name

Please mail this application, all supporting documents, and the non-refundable application fee of $228.00 to:

USPS First-Class Mail:
California Department of Public Health
Radiologic Health Branch, MS 7610
Accounts Receivable and Cashiering Unit
P.O. Box 997414
Sacramento, CA 95899-7414, *or*

Express Mail:
California Department of Public Health
Radiologic Health Branch, MS 7610
Accounts Receivable and Cashiering Unit
1500 Capitol Ave., Suite 520, Bldg. 172
Sacramento, CA 95814-5006

I certify that the information provided with this application is true and correct. I understand that the California Department of Public Health may revoke certificates that are procured by fraud, misrepresentation, or mistake, or for the nonpayment of fees. Further, I am aware that it is unlawful to use X-rays on human beings in this state unless certified pursuant to the Radiologic Technology Act, acting within the scope of that certification, and acting under the supervision of a licentiate of the healing arts who is a certified supervisor or operator.

Signature	Date