APPLICATION FOR APPOINTMENT
BOARD OF MEDICAL RADIOGRAPHY
(MEDICAL RADIOGRAPHER MEMBER)

PLEASE PRINT OR TYPE
Name:

_____ _____
First Middle Last Credentials (ie, PhD, etc., if applicable)

Mailing Address:

_____
Street/Box/RR

_____
City State Zip

Business Telephone _____ Cell/Pager _____ Residence Telephone _____

Email Address _____ FAX Number _____

Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Committee Meetings? Yes No

Please indicate how you became aware of this vacancy on this Committee. Professional Association DHHS Web Page

Newspaper Other (please explain)_____

ELIGIBILITY REQUIREMENTS

Do you hold a current Nebraska license to practice as a medical radiographer? Yes No (Statutes require the medical radiographer members of the board shall have held and maintained an active medical radiographer license for a period of five years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as a medical radiographer for the five (5) years just preceding this application? Yes No (Statutes require the medical radiographer members of the board shall have been actively engaged in practice as a medical radiographer for a period of five years just preceding appointment and shall maintain such practice while serving as a board member. Active practice means devoting a substantial portion of time to rendering professional services.)

Provide the number of years you have been engaged in the practice of medical radiography _____

Have you been a resident of the State of Nebraska for at least one (1) year? Yes No (Statutes require every member of the board shall have been a resident of Nebraska for one year and shall remain a resident of Nebraska while serving as a board member.)

EDUCATION

Degree/Specialty	School Name & Location	From	To	Completion Date

PLEASE COMPLETE REVERSE SIDE

DETAILED DESCRIPTION OF WORK EXPERIENCE ASA MEDICAL RADIOGRAPHER WITHIN THE LAST FIVE YEARS IN NEBRASKA

Position Title	Name & Location	From	To	Average # of Hours/Week

ADDITIONAL INFORMATION

Describe your interest in this profession and why you wish to serve on this Board.

_____

_____

_____

_____

_____

Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions?
Yes ☐ No ☐ If yes, explain.

_____

_____

Have you ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes ☐ No ☐

Are you currently under investigation? Yes ☐ No ☐

Are you a veteran of the U.S. Armed Forces, or National Guard? Yes ☐ No ☐

If yes, is your military experience related to your current practice? Yes ☐ No ☐

I swear and affirm that all information I have provided on this application is true and complete to the best of my knowledge.

_____ _____
Signature Date

Return completed Application to: Monica Gissler, State Board of Health,
DHHS, Division of Public Health, Licensure Unit/RPQI, P.O. Box 95026, Lincoln, NE 68509-5026
402/471-6515; FAX 402/471-0383; Monica.gissler@nebraska.gov