NOTICE TO RADIOGRAPHERS, RADIATION THERAPISTS, NUCLEAR MEDICINE TECHNOLOGISTS AND RADIOLOGIST ASSISTANTS

The Maryland Board of Physicians (the Board) issues licenses to eligible applicants year round. If deemed eligible for licensure, when do you wish to be **licensed**? Please read Page 2 carefully, make your choice, complete the form, and return it with your application to the Board.

Thank you for your cooperation.

PLEASE COMPLETE PAGE 2 OF THIS FORM

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, MD 21215-0095

APPLICATION FOR LICENSURE FOR RADIOGRAPHERS, RADIATION THERAPIST, NUCEAR MEDICINE TECHNOLOGISTS AND RADIOLOGIST ASSISTANTS

Applicant's Preferred Date of License

Licenses for Radiographers, Radiation Therapists, Nuclear Medicine Technologist and Radiologist Assistants expire on April 30, 2011 of every odd year regardless of the date the Board issued the license.

The Maryland Board of Physicians (the Board) issues licenses to eligible applicants year round. Applicants eligible for licensure may choose to be licensed **BEFORE** April 30, 2011 or **AFTER** April 30, 2011.

Instructions: Please choose Option 1 or Option 2. Print your name, sign and date the form, and include it with your application for licensure. The Board will issue the license only upon receipt of this signed form.

Option 1

______ If determined eligible for licensure, I want to be licensed **BEFORE** April 30, 2011. If licensed, I understand that: (1) I will be required to renew the license and pay a renewal application fee before the license expires on April 30, 2011; and (2) the Board will issue the license only upon receipt of this signed form.

Signature: ____ Date: ________________

Name in Print: ____

****

Option 2

______ If determined eligible for licensure, I want to be licensed **AFTER** April 30, 2011. If licensed, I understand that: (1) the license will be effective on May 1, 2011 or later; (2) the license will expire April 30, 2013; (3) I **MAY NOT** work as a radiographer, radiation therapist, nuclear medicine technologist or a radiologist assistant in Maryland **prior** to receiving my license; and (4) the Board will issue the license only upon receipt of this signed form.

Signature: ____ Date: ________________

Name in Print: ____

MARYLAND BOARD OF PHYSICIANS
RADIOLOGIST ASSISTANT APPLICATION FOR LICENSURE

Baltimore, Maryland
410-764-4777
www.mpb.state.md.us

Dear Applicant:

Attached is an application packet for licensure as a Radiologist Assistant in Maryland. The application fee is **$150.00** and is **non-refundable.** Please make your check or money order payable to**: Maryland Board of Physicians.** Mail your application and check to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Applicants for licensure as a radiologist assistant in Maryland must be currently licensed as a radiographer in Maryland and be currently registered with American Registry of Radiologic Technologists as a radiographer and a registered radiologist assistant.

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.**

Applications are processed in order of receipt. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact you if additional documentation is required. Please make sure your contact information is current.

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school. Verification of national certification must come from the national certifying body and verification of other licenses must come from the state board that issued your license.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 7 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

The Board's website is updated every 24 hours. You may wish to check the website at *www.mbp.state.md.us* before calling the Board to find out if a license was issued to you. When you get to the website, click Search Practitioner Profiles.

We look forward to receiving your completed application and will process it as quickly as possible.

The Allied Health Division
Board of Physicians

RRA
10/2009

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4777 800-492-6836
www.mpb.state.md.us

APPLICATION FOR LICENSURE OF RADIOLOGIST ASSISTANTS

INSTRUCTIONS AND IMPORTANT INFORMATION

Individuals applying for licensure as a Radiologist Assistant in Maryland must be: (a) currently licensed as a radiographer in Maryland and (b) currently registered with American Registry of Radiologic Technologists as a radiographer and a registered radiologist assistant.

1. **Name**: If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

2. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.

3. **Public Address:** The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

4. **Contact Information (Telephones and E-mail Address):** The Board will contact you using the information provided.

5. **Date of Birth**: Health Occupations Article §14-5B-09(b)(2), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.

6. **Gender:** Disclosure of Gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity:** Disclosure of race or ethnicity is not requirements of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

9. **Maryland Radiography License Number:** Applicants for licensure as a radiologist assistant must be licensed by the Board as a radiographer.

10. **Expiration Date:** Your radiography license must be current.

11. **Employment Activities:** Please complete and include all employment history beginning with the date you graduated from an accredited radiography program.

12. **Verification of Education:** Complete the top portion of the Verification of Professional Education form (RRA 1) and forward it to the radiologist assistant program from which you graduated. The program must be an academic program recognized by the American Registry for Radiologic Technologists (ARRT) with a nationally recognized radiology curriculum that results in a baccalaureate degree, post baccalaureate certificate, or graduate degree and incorporates a radiologist-directed clinical preceptorship.

13. **Advanced Cardiac Life Support:** Applicants for licensure as a radiologist assistant must be currently certified in advanced cardiac life support. Please provide a copy of your current ACLS certification.

14. **National Certification:** Verification of registration from the American Registry for Radiologic Technologists (ARRT). Applicants for licensure as a radiologist assistant must be currently registered with ARRT in radiography and as a radiologist assistant. Please provide copies of both registrations. Board staff will verify the registration on the ARRT's website. If you are not listed on the website, please have the ARRT send verification of registration to the Board for both categories.

15. **Licensure in Other States:** If you have ever held a license, certification or registration to practice as a radiologist assistant in any state or jurisdiction or in ANY other health care profession in any other (states), including Maryland, complete the top portion of the Verification of Other State Licenses form (RRA 2) and send it to the licensing board in each state in which you are or have been licensed/certified/ registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians, you do not need to complete the RRA 2 form.

16. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation of a "Yes" response and the required supporting documentation will delay the review process.

17. **Release:** Sign and date the certification. You are giving the Board and the Radiation Therapy, Radiography, Nuclear Medicine Technology and Radiologist Assistance Advisory Committee permission to request additional information to support your application for licensure.

18. **Optional Third Party Release:** If you wish the Board to release your information to a third party, complete the third party release statement.

19. **Cooperation in an Investigation**: You may be asked to cooperate fully with any request for information related to your practice as a Radiologist Assistant.

20. Certification and Passport Quality Photo: Sign and date the certification in the presence of a notary public after you have affixed a recent passport quality (2" x 2") photo to the application in the space provided.

Radiologist Assistant Advanced Procedures: Radiologist Assistants have a defined scope of practice under Code of Maryland Regulations (COMAR) 10.32.10.11. (See pages i and ii). The type of supervision depends upon the procedure being performed. Certain procedures require Board-approval before a radiologist assistant may perform them.

Complete the **Radiologist Assistant Advanced Procedures Request Application** if you are requesting approval to perform these duties.

Supplemental Forms RRA1 and RRA2 - Complete **RRA1 Verification of Education** and send it to the institutions where you completed your radiologist assistance educational program. Complete RRA2 Verification of Other State Licenses if you issued a license/certification/registration as a radiologist assistant, radiographer or other health care provider.

Licensure and Renewal: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on April 30th of the first odd year following the date on which you are initially licensed and you will have to renew your license if you plan to continue practicing in Maryland. The renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the current address on file. **You will be required to renew your license by April 30th of the first odd year whether or not you receive the renewal notice.**

PRACTICING AS A RADIOLOGIST ASSISTANT: A person may not practice, attempt to practice, or offer to practice as a radiologist assistant in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides radiologist assistant unless the person is licensed to practice by the Board. Individuals practicing without a license may be fined up to $5,000.

The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board ADA designee, Ellen Douglas Smith at (410)764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Smith.

RADIOLOGIST ASSISTANT LICENSURE APPLICATION 10/2009

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date ____________
Check Number ____________
Amt Paid ____________
Name Code____________
App ID: 54
Fee: $150

APPLICATION FOR LICENSURE: RADIOLOGIST ASSISTANT

Please print legibly or type the required information. Do not leave any item unanswered.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.):

First name and middle name:

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

City State Zip Code -

3. **Public Address:** Your public address of record. This address, usually your place of employment, is available to the public and will be posted on the Internet.

Street Address: **If you change your address prior to be licensed, notify the Board in writing.**

City State Zip Code -

4. **Telephone (s)**: Home - - Office: - -

Cell/Pager: - - E-mail address:

5. **Date of Birth:** Month Day Year

6. **Gender:** ☐ Male ☐ Female

7. **Race:** Check all that apply ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

8. **Social Security Number:** - -

9. **MD Radiography License #: R000___ ___ ____ ____**

10. **Expiration Date: ____________________________**

For Board Use Only	
	License Number:
	Date Issued:
	Licensed By:________________________________

Print Your Name: ______________________________ Date:____________

11. Chronology of Employment Activities: Beginning with the date you graduated from your accredited radiography program and continuing through the present, list chronologically all of your employment activities. Explain any lapse in time over one year in which you were not employed. Include non-health related employment history. Please photocopy this page if more space is needed. Sign and date all additional pages.

Graduation Date from Radiography Program:
Month: __________ Year: ___________

Employment activities after graduation from Radiography Program

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

month	year	TO	month	year	**Activity/Position:**
Name and telephone of Supervisor:					**Name and Address of Employer:**

CONTINUED ON PAGE 3: **If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.**

Print
Your
Name: ______________________________ Date:______________

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity/Position:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity:
Name and telephone of Supervisor:					Name and Address of Employer:

month	year	TO	month	year	Activity:
Name and telephone of Supervisor:					Name and Address of Employer:

12. EDUCATIONAL PROGRAM: Please complete this section and send the attached **Verification of Education (RRA 1)** to your radiologist assistant program.

____ ______/______/______

Name of School/Program **Graduation Date**

____

Street Address

____

City **State** **Zip Code**

____

Telephone Number, including area code

13. ADVANCED CARDIAC LIFE SUPPORT: Provide documentation of current ACLS certification.

Expiration date: ____________________________

14. CERTIFYING EXAMINATIONS: List the date and certification/registration number for each exam.

CATEGORY	DATE OF EXAMINATION	CERTIFICATION NUMBER
Radiography	______/______/______	____________________
Radiologist Assistant	______/______/______	____________________

Print Your Name: ______________________________ Date:______________

15a. Licensure as a Radiologist Assistant. List all states or other jurisdictions in which ever held a license to practice as a Radiologist Assistant. Please complete and mail the attached **Verification of Other State License(s)** form **(RRA2)** to the appropriate state board(s). If you have never been licensed as a Radiologist Assistant, write N/A here ____________________.

State	License #	Category (RT(R); PA, etc.)	Year Issued	Expiration Date

15b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license to practice in ANY other health occupation, including radiographer. Please complete and mail the attached **Verification of Other State License(s)** form **(RRA 2)** to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here ______________________________.

State	License #	Category (RT(R); PA, etc.	Year Issued	Expiration Date

Print
Your
Name: ____________________ Date:__________

16. Character and Fitness Questions (Check either **YES** or **NO**)

	YES	NO	
a.	☐	☐	Have you ever been denied a license, certification or registration to practice any health occupation? **(ex: state board orders and/or charges; adverse or disciplinary actions in any healthcare facility)**
b.	☐	☐	Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? **(ex: state board orders and/or charges; adverse or disciplinary actions)**
c.	☐	☐	Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? **(ex: state board orders and/or charges; adverse or disciplinary actions)**
d.	☐	☐	Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? **(ex: provide name of institution, correspondence received or sent, related documents.)**
e.	☐	☐	Have you ever been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? **(ex: police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**
f.	☐	☐	Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? **(ex: police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**
g.	☐	☐	Do you currently have a physical or mental condition which may affect your ability to practice your profession**? (ex: medical evaluations)**
h.	☐	☐	Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? **(ex: malpractice claims)**
i.	☐	☐	Have you ever been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, type of discharge. **(ex: DD214)**
j.	☐	☐	Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? **(ex: copy of charges)**

»»» **If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Examples of documentation is next to the question. Please note that these examples are not all inclusive. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.**

RELEASE AND CERTIFICATION

17. Release:

I agree that the Maryland Board of Physicians (the Board) and Radiation Therapy/Radiography/Nuclear Medicine Technology and Radiologist Assistance Advisory Committee may request any information necessary to process my application for licensure as a Radiologist Assistant in Maryland from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Applicant's Name (Printed) ______________________ Applicant's Signature ______________________ Date __________

18. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

The Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: ______________________

Phone: ______________________ Applicant's Signature ______________________ Date __________

19. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed radiologist assistant in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-5B-14.

Applicant's Signature ______________________ Date __________

20. Certification: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 14-5B-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.10 which govern the practice of Radiologist Assistants in Maryland.

Applicant's Signature ______________________ Date __________

STATE OF ______________________

CITY/COUNTY OF ______________________

I HEREBY CERTIFY that on this __________ day of ______________, 20 ______ , before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, ______________________ (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law that signing the foregoing application was his voluntary act and deed.

AS WITNESS my hand and notorial seal. ______________________ Notary Public

My Commission expires: ______________ SEAL

APPLICANT:

PASTE YOUR PASSPORT-QUALITY PHOTO HERE BEFORE NOTARIZING

STOP! Completed application and check for $150 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

RADIOLOGIST ASSISTANT SCOPE OF PRACTICE—The procedures on this page do not require Board approval. (COMAR 10.32.10.11)

Clinical History and Physical Examination

1. Review the patient's medical record to verify the appropriateness of a specific exam or procedure;
2. Interview the patient to obtain, verify, or update medical history;
3. Explain procedure to the patient or significant others, including a description of risks, benefits, alternatives, and follow-up;
4. Obtain informed consent;
5. Determine if the patient has followed instructions in preparation for the exam such as diet and premedications;
6. Assess risk factors that may be contraindications to the procedure such as health history, medications, pregnancy, psychological indicators, and alternative medicines;
7. Obtain and evaluate vital signs;
8. Perform physical examination and analysis of data such as signs and symptoms, laboratory values, and significant abnormalities, as required by the imaging procedure to be conducted; and
9. Report findings related to items 1—5 to the supervising radiologist.

General Procedures

1. Apply ECG leads and recognize life threatening ECG abnormalities;
2. Perform urinary catheterization;
3. Perform venipuncture;
4. Monitor IV for flow rate and complications;
5. Position patient to perform required procedure, using immobilization devices and modifying technique as necessary;
6. Assess patient's vital signs and levels of anxiety and pain and inform radiologist when appropriate;
7. Recognize and respond to medical emergencies, such as drug reactions, cardiac arrest, and hypoglycemia, and activate emergency response systems, including notification of the radiologist;
8. Administer oxygen as prescribed;
9. Operate a fixed/mobile fluoroscopic unit;
10. Assure documentation of fluoroscopy time;
11. Explain effects and potential side effects to the patient of the pharmaceutical required for the examination;
12. Administer contrast agents as prescribed by the radiologist;
13. Administer general medications, excluding radiopharmaceuticals and narcotic or sedating medications, as prescribed by the radiologist; and
14. Monitor patient for side effects or complications of the pharmaceuticals.

Examinations and Procedures That May Be Performed Under Immediate Available Direction of a Radiologist

In addition to performing contrast media administration, placement of needle or catheter, and operation of imaging equipment, a radiologist assistant may also perform the following procedures under the immediate available direction of a radiologist:

1. Upper GI;
2. Esophagus;
3. Small bowel studies;
4. Barium enema; and
5. Evaluation of percutaneous gastric and enteric tubes.

Examinations and Procedures That May Be Performed Under the On-Site Supervision of a Radiologist

In addition to performing contrast media administration, placement of needle or catheter, and operation of imaging equipment, a radiologist assistant may also perform the following procedures under the on-site supervision of a radiologist:

1. Cystogram and voiding cystourethrogram;
2. Nasoenteric and oroenteric feeding tube placement;
3. Joint injection and aspiration;
4. Arthrogram, including conventional, CT, and MR;
5. PICC placement;
6. Paracentesis with appropriate image guidance;
7. Thoracentesis with appropriate image guidance; and
8. Lumbar puncture under fluoroscopic guidance.

Post Imaging Procedures (Does not require Board approval)

1. Review of imaging procedures, making initial observations, and communicating observations only to the radiologist;
2. Communication of radiologist's report to referring physician;
3. Provision of radiologist-prescribed post-care instructions to patients;
4. Performance of follow-up patient evaluation, and communication of findings to the radiologist;
5. Documenting procedure in appropriate record, and documenting exceptions from established protocol or procedure;
6. Writing patient discharge summary for review and co-signature by radiologist;
7. Participating in quality improvement activities within radiology practice; and
8. Assisting with data collection and review for clinical trials or other research.

Procedures Requiring Board Approval

The Board may approve the following procedures on a case-by-case basis under the level of supervision the radiologist specifies. To be considered for approval, complete the **Radiologist Assistant Advance Procedures Request Application**.

1. Lower extremity venography;
2. Lumbar, thoracic, or cervical myelography;
3. Non-tunneled venous central line placement;
4. Venous catheter placement for dialysis;
5. Breast needle localization;
6. Ductogram (galactogram);
7. T-tube cholangiogram;
8. Retrograde urethrogram;
9. Port injection;
10. Fistulogram,
11. Sinogram;
12. Loopogram;
13. Swallowing study;
14. Hysterosalpingogram; and
15. Other specific procedures approved by the Board.

Radiologist Assistants

Supplemental Forms

RRA 1—Verification of Education

RRA 2—Verification of Other State Licenses

RRA 1
Verification of Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mpb.state.md.us

For Board Use Only
Program accredited?
______ ________
Y N
Date verified ___________

VERIFICATION OF EDUCATION PROFESSIONAL EDUCATION FOR RADIOLOGIST ASSISTANT LICENSURE

Part 1

APPLICANT: Complete Part 1 and send to the institution where you completed your Radiologist Assistant program.

Name: ____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: ________/__________/_______
mm dd yyyy

Social Secuity Number: _____________- __________ - _______________

Professional School of Graduation: ____

Attended from: ________________________________ to ______________________________

Date of Graduation: ____________________________
mm/yyyy

Degree Received: ____________________________________

Applicant's Signature: ______________________________________ Date: ______________________________

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: ____________________________
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree ☐ Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐ Other:____________________
(specify)

in ____.
Educational Program

________________________________ ________________________________
Printed Name of Authorized Official Name of Institution

____________________ ____________________ ____________________
Title of Authorized Official Telephone Number Fax Number

________________________________ ________________________________
Signature of Authorized Official Date

SEAL

OF THE

INSTITUTION

RRA 2
Verification of Licensure in Other States Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

VERIFICATION OF OTHER STATE LICENSES

Part 1

APPLICANT: Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license to practice as a Radiologist Assistant. Also send use this form to send to each state board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: ______________________________

State of Licensure: ______________________________ License Number: ______________________________

Date: ______________________________ Expiration Date: ______________________________

Name: ____
(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : ______________________________ Date of Birth: ______/______/______

Professional School of Graduation: ______________________________ Year: ______________________________

Signature: ______________________________ Date: ______________________________

Part 2

AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

______________________________ ______________________________ ______________________________
License number Date Issued Expiration Date

Is/was the license in good standing? ☐ **Yes** ☐ **No**

If not in good standing is/was it: ☐ **reprimanded** ☐ **suspended** ☐ **revoked** ☐ **surrendered**

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? ☐ **Yes** ☐ **No**

If yes, please explain: ____

____

Other Derogatory Information or Pending Charges: ____

____

____
Printed Name of Authorized Official

____
Title of Authorized Official

____
Signature of Authorized Official

____
Direct Telephone Number

____
Printed Name of State

____
Date