

VERIFICATION OF OTHER STATE LICENSES FOR A LIMITED X-RAY MACHINE OPERATOR

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 **Limited X-Ray Machine Operator**. Also 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 email this form to: [mdh.mbpcredentials@maryland.gov](mailto:mdh.mbpcredentials@maryland.gov).

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

Direct Telephone Number

Title of Authorized Official

Printed Name of State

Signature of Authorized Official

Date

State Board  
Seal