RT(R) 3
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
www.mbp.state.md.us

VERIFICATION OF OTHER STATE LICENSES FOR A RADIOGRAPHER

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 Radiographer. 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*.

_____ _____ _____
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