Radiologist Assistant Certification Application

(For the certification period ending March 31, 2026)

Name: _____
First **Middle** **Last** **Suffix**

Other name(s): _____
First **Middle** **Last (maiden)**

Identifying Characteristics

Sex: ☐ **Male** ☐ **Female**

Height (ft.in): _____

Weight (lbs.): _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

_____

Date attached photo was taken: _____
(mm/dd/yyyy)

Paste or tape a recent color photo taken within the past 12 months, front-view passport-type photo in this square

Personal Information

- In accord with federal law, please be advised that disclosure of your Social Security Number is MANDATORY in order for the Board to comply with the requirements of the federal National Practitioner Data Bank.

Date of Birth: _____ **City:** _____**State/Province:**_____
(mm/dd/yyyy)

County: _____ **Country:** _____

Social Security Number: _____

Professional Education

Degree Earned: **Radiologist Assistant**

Name of School/Program:_____

City: _____ **State/Province:** _____

Country: _____ **Date of Graduation:** _____
(mm/dd/yyyy)

Name: _____

ARRT Certifications – You must be currently certified by the American Registry of Radiologic Technologists (ARRT) as a both Radiologic Technologist and as a Radiologist Assistant.

1. Radiologic Technician ARRT Certification:

   Certification Date: _____ (MM/DD/YYYY) Expiration: _____ (MM/DD/YYYY) ARRT ID: _____

2. Radiology Assistant ARRT Certification:

   Certification Date: _____ (MM/DD/YYYY) Expiration: _____ (MM/DD/YYYY) ARRT ID: _____

Preferred Contact Information - Preferred contact information is the information that the Board will use to contact you. The Board may also contact you at any email address you provide.

Business Name (if applicable): _____

Street Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____ **Fax:** _____

Email Address: _____ **Mobile Telephone:** _____

Home Address - Your home address is your principal place of residence and is a physical address. Please do not use a post office box as your home address.

Street Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____ **Fax:** _____

Primary Work Address - Your primary work address is publicly available on the West Virginia Board of Medicine website.

Business Name (if applicable): _____

Street Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____ **Fax:** _____

Name: _____

Supervising Radiologist(s): A Radiologist Assistant shall perform only under the supervision of a supervising radiologist. You must identify at least one (1) supervising physician and may have up to three (3) supervising radiologists. The supervising radiologist(s) must have an active medical license issued by the West Virginia Board of Medicine and must be Board certified in radiology by a member board of the American Board of Medical Specialties.

Supervising Radiologist #1

Name: _____ WVBOM License No._____

ABMS Certifying Board:_____ Email Address: _____

Work Address: _____Telephone: _____

Address Line 2 (if needed): _____

City: _____ State: _____ Zip Code: _____ County: _____ Fax: _____

Supervising Radiologist #2 (if applicable)

Name: _____ WVBOM License No._____

ABMS Certifying Board:_____ Email Address: _____

Work Address: _____Telephone: _____

Address Line 2 (if needed): _____

City: _____ State: _____ Zip Code: _____ County: _____ Fax: _____

Supervising Radiologist #3 (if applicable)

Name: _____ WVBOM License No._____

ABMS Certifying Board:_____ Email Address: _____

Work Address: _____Telephone: _____

Address Line 2 (if needed): _____

City: _____ State: _____ Zip Code: _____ County: _____ Fax: _____

Name: _____

Licensure/Registration/Certification History and Status: Please list each and every state and commonwealth where you have ever held a professional license, registration and/or certification as a radiologic assistant and/or radiologic technologist, and provide the requested information.

State	Credential Type (Radiologist Assistant or Radiologic Technologist)	Credential Number	Date Issued	Status

Name: _____

Professional Practice, Character, and Fitness Questions: Please provide complete and accurate answers to the following questions concerning your professional licensure, registrations and certifications. **For the purpose of these questions, "professional credential" means a license, certification or registration to provide radiographic services issued by any state or commonwealth of the United States.**

ALL YES ANSWERS MUST BE ACCOMPANIED BY A WRITTEN EXPLANATION, SIGNED AND DATED BY YOU, EXPLAINING IN DETAILYOUR YES ANSWER(S). YOU MUST ALSO ENCLOSE OR CAUSE TO BE SUBMITTED ALL REQUESTED SUPPORTIVE DOCUMENTATION.

	Yes	No
1. Do you have any limitations, restrictions or conditions placed upon any of your professional credentials by any issuing board?		
2. Have you had a professional credential revoked, suspended, or placed on probation?		
3. Have you surrendered a professional credential?		
4. Have you had disciplinary action taken against your professional credential in any jurisdiction?		
5. Are you currently under investigation or subject to an administrative complaint in any jurisdiction related to your professional conduct or professional practice?		
6. Have you been called before or appeared before any board or panel for discussions or questions concerning violations of the law or rules pertaining to your professional practice, or for unethical conduct?		
7. Have you ever been charged with or convicted of or pled nolo contendere to any felony or misdemeanor? If your answer is yes, submit with your application certified copies of all court records related to any such charges, please and/or convictions.		
8. Have you had any hospital privileges limited, restricted, suspended revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation? If your answer is yes, you must have the facility submit directly to the Board all documentation related to your answer.		
9. Have you had any judgments or settlements arising from professional liability rendered or made against you? For each medical professional liability judgment or settlement you report, please provide: (1) the name of the patient(s) alleging medical professional liability; (2) the date of loss; (3) the date of the settlement or judgement; (4) the amount of the settlement or judgement against you; (5) the name of the insurance company providing coverage to you with respect to this claim; and (6) a brief description of the allegations and a summary of the care provided. Your application is incomplete until all of the requested information is submitted for each settlement and/or judgement.		

Original Signature: _____ **Date:** _____

Name: _____

Acknowledgement / Certification

By affixing my personal signature to this application, I hereby certify:

Personal Completion of Application and Accuracy. I have personally completed this Radiologist Assistant Certification Application, and I am solely responsible for the accuracy and completeness of the information provided. I have carefully read and understood all of the questions and have answered them completely, without reservations of any kind. I declare that my answers and all statements made by me herein are true, correct and complete. I understand that any authorization to practice issued to me is based on the truthfulness of the information I have provided and my statements herein. I hereby agree and understand that providing false or incomplete information on this application constitutes good cause for disciplinary action and/or the subsequent revocation of any practice authorization issued to me by this Board.

Duty to Supplement. I understand and agree that if anything should occur which would change how I responded to any of the application questions, or which would render my original responses untrue, inaccurate or incomplete, I have a duty to supplement my responses until such time as I am notified by the Board that it has acted upon this application.

Duty to Maintain Current Contact Information. I understand that I have an obligation to maintain complete and up-to-date contact information with the West Virginia Board of Medicine and agree to provide updated contact information within 10 business days of any change to the information submitted with this application.

Supervision of Radiologist Assistants. I understand that RAs, whether employed by a health care facility or the supervising radiologist, shall only perform RA duties under the supervision and control of the supervising radiologist and at the same practice location as the supervising radiologist.

Renewal. I understand that the Board of Medicine issues Radiologist Assistant Certifications for a specific term which expires on March 31st of odd years. If I intend to continue to provide RA services to patients located in West Virginia after the initial term of certification, I must apply for certification renewal.

Performance Report. I understand that in association with certification renewal, RAs and their supervising radiologist(s) must submit a performance report to the Board, signed either individually or combined, regarding the professional conduct, capabilities and performance of the RA.

Discipline and Jurisdiction. If granted a Radiologist Assistant Certification, I understand and agree that I am subject to the laws, rules and regulations of West Virginia governing my profession, including the state judicial system and all professional conduct rules and standards incorporated into the practice act governing my profession and the Board's legislative and procedural rules. I acknowledge and agree that I am subject to the jurisdiction of the West Virginia Board of Medicine, including the Board's complaint, investigation and hearing process.

Original Signature: _____ Date: _____