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

PLEASE PRINT OR TYPE

Name: First _____ Middle _____ Last _____

Credentials, i.e. PhD, RN, MS, etc. _____

Address: Street/Box/RR _____

City _____ State ____ Zip _____

Work Phone _____ Cell/Pager _____ Home Phone _____

Email Address _____ FAX Number _____

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

Please indicate how you became aware of this vacancy on this Board.
Professional Association ☐ DHHS Web Page ☐ Newspaper ☐ Other ☐ (please explain)

ELIGIBILITY REQUIREMENTS

Do you hold a current Nebraska license to practice as a limited radiographer? Yes ☐ No ☐ (Statutes require the limited radiographer member of the board shall have held and maintained an active limited radiographer license for a period of five (5) years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as a limited radiographer for the five (5) years just preceding this application? Yes ☐ No ☐ (Statutes require the limited radiographer members of the board shall have been actively engaged in practice as a limited 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.)

Years you have worked in the practice of limited medical radiography _____

Have you been a resident of the State of Nebraska for the previous 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

School _____ Location _____

Degree/Specialty _____ Completed Date _____

School _____ Location _____

Degree/Specialty _____ Completed Date _____

PLEASE COMPLETE REVERSE SIDE

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

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

ADDITIONAL INFORMATION

Describe your interest in medical radiography 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, P.O. Box 95026, Lincoln, NE 68509-5026
402/471-6515; FAX 402/471-0383; monica.gissler@nebraska.org

9/27/2018