



The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Bureau of Environmental Health
Radiation Control Program
Schrafft Center, Suite 1M2A
529 Main Street, Charlestown, MA 02129
Phone: 617-242-3035 Fax: 617-242-3457
www.mass.gov/dph/rcp

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

APPLICATION FOR AN INDIVIDUAL GRADUATED FROM A JOINT REVIEW
COMMITTEE ON EDUCATION IN RADIOLOGIC TECHNOLOGY (J.R.C.E.R.T.)
APPROVED RADIOLOGIC TECHNOLOGIST PROGRAM(S)

1. _____ / _____ / _____
 NAME (PLEASE PRINT) DATE OF BIRTH

ADDRESS

CITY/TOWN STATE/ZIP

SS# HOME TELEPHONE DAYTIME TELEPHONE

2. RADIOLOGIC TECHNOLOGIST TRAINING:

Dates of training completed _____ / _____ to _____ / _____
month year month year

Date of graduation: _____ / _____
month year

Area of Study: _____ radiography, full

_____ nuclear medicine

_____ radiation therapy

College providing training:

Name: _____

Address: _____

3. NOTE: Attached to this form, you must include proof of successful completion of all school requirements either in the form of a letter signed by your program director indicating your course completion on school letter head, or a copy of your diploma/certificate showing graduation from a radiologic technologist program.

4. HAVE YOU EVER BEEN CONVICTED OF A FELONY? ___NO ___YES

IF YES PLEASE EXPLAIN:

5. I, _____, hereby apply for a temporary license as a radiologic technologist. I have read and understand the provisions of the Commonwealth of Massachusetts Law, Chapter 111 Section 5K, and the regulations established by the Commission. I further grant permission to the licensing agency to verify any or all of the information that I have furnished.

Applicant's Signature: _____ Date: _____

6. RETURN TO: RADIATION CONTROL PROGRAM
RADIOLOGIC TECHNOLOGIST LICENSING
SCHRAFFT CENTER, SUITE 1M2A
529 MAIN STREET
CHARLESTOWN, MA 02129