

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

410-764-4777

www.mpb.state.md.us

RADIOGRAPHER APPLICATION FOR LICENSURE

Dear Applicant:

Attached is an application packet for licensure as a **Radiographer** in Maryland. The application fee is **\$150.00** and is **non-refundable**. Please make your check or money order payable to: **Maryland Board of Physicians**.

Mail your application and check to:

**Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297**

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.**

Applications are processed in order of receipt. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact you if additional documentation is required. Please make sure your contact information is current.

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school. Verification of full-time practice must come directly from an employer, supervisor, or colleague. Verification of national certification must come from the national certifying body and verification of other licenses must come from the state board that issued your license.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 7 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

The Board's website is updated every 24 hours. You may wish to check the website at www.mbp.state.md.us before calling the Board to find out if a license was issued to you. When you get to the website, click Look up a Licensee.

We look forward to receiving your completed application and will process it as quickly as possible.

The Allied Health Division
Board of Physicians



Maryland Board of Physicians

Check One:

Initial Licensure

Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

“Veteran” means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.

“Veteran” does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.

“Military Spouse” means the spouse of a service member or veteran,

“Service Member” means an individual who is an active duty member of:

“Military Spouse” includes a surviving spouse of:

- * A veteran; or
- * A service member who died within one year before the date on which the application for license, certification, or registration is submitted.

- * The Armed Forces of The United States
- * A reserve component of the Armed Forces of the United States; or
- * The National Guards of any state

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

- Service Member – Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation..**
- Veteran – Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**
- Military Spouse: **Check the appropriate box**
 - Spouse is a Veteran. **Provide supporting documentation.**
 - Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
 - Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

Name of Applicant (PRINT)

Military Branch

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217

Baltimore, Maryland 21297

Telephone: 410-764-4777 800-492-6836

www.mpb.state.md.us

APPLICATION FOR LICENSURE OF RADIOGRAPHER

INSTRUCTIONS AND IMPORTANT INFORMATION

If you have been previously certified/licensed in Maryland as a radiographer, DO NOT USE THIS APPLICATION. Download a copy of the reinstatement application from the Board's website at www.mpb.state.md.us.

- 1. Name:** If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.
- 2. Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.
- 3. Public Address:** The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.
- 4. Contact Information (Telephones and E-mail Address):** The Board will contact you using the information provided.
- 5. Date of Birth:** Health Occupations Article §14-5B-09(b)(2), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.
- 6. Gender:** Disclosure of Gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.
- 7. Race and Ethnicity:** Disclosure of race or ethnicity is not requirements of licensure, but the information provided will be used for identification purposes and for criminal background checks only.
- 8. Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:
 - A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
 - B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
 - C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
 - D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

- 9. Employment Activities:** Please complete and include all employment history beginning with the date you graduated from a radiography program.
- 10. Verification of Education:** Complete the top portion of the Verification of Professional Education form **(RT(R) 1)** and forward it to the JRCERT-accredited radiography program from which you graduated.
- 11. Verification of Full-time Practice Experience as a Radiographer:** Complete Section I of this form **(RT(R) 2)** if you did not graduate from a JRCERT-accredited radiography program and send it to an employer, supervisor or colleague to complete and return to the Board. Complete qualifications are explained in item 11 in the application and on form **(RT(R) 2)**.
- 12. National Certification:** Verification of registration from the American Registry for Radiologic Technologists (ARRT). Applicants for licensure as a Radiographer must be currently registered with ARRT in radiography and as a Radiographer.
- 13. Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by:
 - a. Graduation from an English-speaking high school or undergraduate school after at least 3 years of enrollment; **OR**
 - b. Graduation from a recognized English-speaking professional school with acceptable proof of proficiency in the oral and written communication of English; **OR**
 - c. Provide evidence that you achieved at least a passing score of 26 on the spoken part and at least 79 on written part of the Test of English as Foreign Language (TOEFL).
- 14. Licensure in Other States:** If you have ever held a license, certification or registration to practice as a Radiographer in any state or jurisdiction or in ANY other health care profession in any other (states), including Maryland, complete the top portion of the Verification of Other State Licenses form **(RT(R) 3)** and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form.
- 15. Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation of a "Yes" response and the required supporting documentation will delay the review process.
- 16. Release:** Sign and date the certification. You are giving the Board and the Radiation Therapy, Radiography, Nuclear Medicine Technology and Radiologist Assistance Advisory Committee permission to request additional information to support your application for licensure.
- 17. Optional Third Party Release:** If you wish the Board to release your information to a third party, complete the third party release statement.
- 18. Cooperation in an Investigation:** You may be asked to cooperate fully with any request for information related to your practice as a Radiographer.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

19. Certification and Passport Quality Photo: Sign and date the certification in the presence of a notary public after you have affixed a recent original passport quality (2" x 2") color photo to the application in the space provided.

Supplemental Forms:

- ◆ **RT(R)1 and -** Complete **RT(R)1 Verification of Education** and send it to the institutions where you completed your JRCERT-accredited radiography educational program.
- ◆ **RT(R)2:** Complete **RT(R)2 Verification of Full-time Practice Experience as a Radiographer** if you did not graduate from a JRCERT-accredited educational program and meet additional qualifications.
- ◆ **RT(R)3:** Complete **RT(R)3 Verification of Other State Licenses** if you issued a license/certification/registration as radiographer or ANY other health care provider.

Licensure and Renewal: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on April 30th of the first odd year following the date on which you are initially licensed and you will have to renew your license if you plan to continue practicing in Maryland. The renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the current address on file. **You will be required to renew your license by April 30th of the first odd year whether or not you receive the renewal notice.**

The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board ADA designee, Yemisi Koya at (410)764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Koya.

PRACTICING AS A RADIOGRAPHER: A person may not practice, attempt to practice, or offer to practice as a Radiographer in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides radiography unless the person is licensed to practice by the Board. Individuals practicing without a license may be fined up to \$5,000.

9. Chronology of Employment Activities: Beginning with the date you graduated from your accredited radiography program and continuing through the present, list chronologically all of your employment activities. Explain any lapse in time over one year in which you were not employed. Include non-health related employment history. Please photocopy this page if more space is needed. Sign and date all additional pages.

Graduation Date from Radiography Program:
 Month: _____ Year: _____

Employment activities after graduation from Radiography Program

month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		
		TO			Activity/Position:
Name and telephone of Supervisor:			Name and Address of Employer:		

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		

10. EDUCATIONAL PROGRAM: *To qualify for a license, the program must be accredited by or have been accredited by the Joint Review Committee on Education Programs in Radiologic Technology (JRCERT) or its predecessor or successor at the time of graduation. <http://www.jrcert.org/>. Please complete this section and send the attached **Verification of Education (RT(R) 1)** to your accredited Radiography program.*

_____/_____/_____
Name of School/Program Graduation Date

Street Address

City State Zip Code

Telephone Number, including area code

11. Alternative Educational Pathway — *This pathway is **ONLY** for applicants who did not graduate from a JRCERT-accredited educational program, but may qualify for licensure by another educational pathway. To qualify for licensure, the applicant must meet the following requirements:*

- Did not graduate from a Joint Review Committee on Education in Radiologic Technology (JRCERT)-accredited radiography program;
- Graduated from a radiography program that is recognized by the American Registry of Radiologic Technologists (ARRT). This means that you were eligible to sit for the ARRT exam;
- Possess a current, active, unrestricted license as a radiographer in another state or is otherwise recognized as a radiographer in another state;
- *Have at three (3) years full-time experience as a radiographer in another state. The three (3) years of experience must have occurred within the last five (5) years immediately preceding the submission of the application; and
- Have no history of public disciplinary action taken, or pending, against any license currently or previously held or expired.

*An employer, supervisor or colleague must verify your employment history. Complete Section I of the **RT(R)2** supplemental form and send it to an employer, supervisor or colleague.

12. National Certification: List the date and certification/registration number.

ARRT Certificate/Registration Number _____

Certification/Registration Date ____/____/____

13. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

- I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment; **OR**
- I graduated from a recognized English-speaking professional school; **OR**
- I achieved a passing score of at least 26 on the spoken part **and** at least 79 on the written part of the Test of English as a Foreign Language (TOEFL).

14a. Licensure as a Radiographer. List all states or other jurisdictions in which ever held a license to practice as a Radiographer. Please complete and mail the attached **Verification of Other State License(s)** form **(RT(R)3)** to the appropriate state board(s). If you have never been licensed as a Radiographer, write **N/A** here _____.

State	License #	Category (RT(R); PA, etc.)	Year Issued	Expiration Date

14b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s)** form **(RT(R) 3)** to the appropriate state board(s). If you have never been licensed in any other health occupation, write **N/A** here _____.

State	License #	Category (PA, RN, etc.)	Year Issued	Expiration Date

15. Character and Fitness Questions (Check either YES or NO)

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been denied a license, certification or registration to practice any health occupation? (ex: state board orders and/or charges; adverse or disciplinary actions in any healthcare facility) |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? (ex: state board orders and/or charges; adverse or disciplinary actions) |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? (ex: state board orders and/or charges; adverse or disciplinary actions) |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? (ex: provide name of institution, correspondence received or sent, related documents.) |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? (ex: police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement) |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? (ex: police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement) |
| g. | <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have a physical or mental condition which may affect your ability to practice your profession? (ex: medical evaluations) |
| h. | <input type="checkbox"/> | <input type="checkbox"/> | Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? (ex: malpractice claims) |
| i. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, type of discharge. (ex: DD214) |
| j. | <input type="checkbox"/> | <input type="checkbox"/> | Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? (ex: copy of charges) |

»»» If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Examples of documentation is next to the question. Please note that these examples are not all inclusive. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

Radiographer

Supplemental Forms

RT(R) 1—Verification of
Education

RT(R) 2—Verification of
Full-time Practice
Experience as a radiographer

RT(R) 3—Verification of
Other State Licenses

**VERIFICATION OF EDUCATION PROFESSIONAL EDUCATION FOR
RADIOGRAPHER LICENSURE**

Part 1

APPLICANT: Complete Part 1 and send to the institution where you completed your Radiography program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: ____/____/____ Social Security Number: ____-____-____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: ____/____/____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

Associate's Degree Certificate Bachelor's Degree Master's Degree Other: _____
(specify)

in _____ Educational Program. The program was accredited by: _____
CAHEA, CAAHEP, JRCERT

Printed Name of Authorized Official Name of Institution

Title of Authorized Official Telephone Number Fax Number

Signature of Authorized Official Date

SEAL
OF THE
INSTITUTION

RT(R)2
Verification of
Practice Experience
Supplemental Form

Maryland Board of Physician
Allied Health Unit
P.O. Box 2571
Baltimore, Maryland 21215
Telephone: 410-764-4777 or 800-492-6836
Email: mbpmail@rcn.com

**Application for Licensure: Radiographer
Verification of Full-time Practice Experience as a Radiographer**

General Instructions and Important Information

Complete the form only if you meet the following education qualifications:

- Did not graduate from a Joint Review Committee on Education in Radiologic Technology (JRCERT)-accredited radiography program;
- Graduated from a radiography program that is recognized by the American Registry of Radiologic Technologists (ARRT);
- Possess a current, active, unrestricted license as a radiographer in another state or are otherwise recognized as a radiographer in another state;
- Have at least three (3) years of full-time practice experience as a radiographer in another state. The minimum of three (3) years of practice experience must have occurred within the last five (5) years immediately preceding the submission of the application; and
- Have no history of public disciplinary action taken, or pending, against any license currently or previously held or expired.

An Applicant who meets the above qualifications must have an employer, supervisor or colleague verify, on the attached form **RT(R)3**, that the Applicant has satisfactorily practiced radiography on a full-time basis for at least three (3) of the last five (5) years immediately preceding the submission of application.

? Instructions for the Applicant:

1. Complete Part 1.
2. Send the form to an employer, supervisor or colleague. Have the employer, supervisor or colleague complete Part 2 and return the form directly to the Board of Physicians. **The Board will not accept the form from the Applicant.**

NOTE: You may send copies of the form with Part 1 completed to all individuals necessary to verify that you have a minimum of three (3) years of full-time practice as a radiographer in another state. A minimum of three (3) years of the practice experience must have occurred within the last five (5) years immediately preceding the submission of the application.

? Instructions for Completion of Part 2:

Part 2 must be completed by the employer, supervisor or colleague with personal knowledge of the Applicant's full-time practice as a radiographer.

The employer, supervisor or colleague completing Part 2 must send the form directly to:

Maryland Board of Physicians
Allied Health Unit
P.O. Box 2571
Baltimore, Maryland 21215

**** Do not return the form to the Applicant.****

VERIFICATION OF FULL-TIME PRACTICE EXPERIENCE AS A RADIOGRAPHER

Verification of at least three (3) years of satisfactory, full-time practice experience as a radiographer in another state is required for applicants who have not graduated from a JRCERT-accredited radiography program. The minimum of three (3) years of full-time radiographer experience must have occurred within the last five (5) years immediately preceding the submission of the application.

Part 1 Applicant: Complete Part 1 only and send to your employer, supervisor or colleague for verification.

Name: _____
Last Name and Generational Indicator (Jr, III, etc.) First Name Middle Name Former Name

Address: _____
Street Address City State Zip Code

Telephone Number: _____ **Email Address:** _____

Applicant's Signature: _____ **Date:** _____

Part 2 Employer, supervisor or colleague: Verify the practice experience of the Applicant named above.

**** When Part 2 is completed, mail this form to the Board of Physicians' address noted at the top of this page. ****

1. In what capacity did you or do you work with the above-named Applicant? Please check all that apply.

Employer Supervisor Colleague

2. Dates you have worked with the Applicant: From: _____ **to** _____

3. Was the Applicant's practice experience full-time? Yes No

4. Dates the Applicant worked full-time (if different than dates in Item 2): From _____ **to** _____

5. Name of practice site: _____

6. Address of practice site: _____

7. Was the work the Applicant performed as a radiographer satisfactory? Yes No

8. Additional comments:

Printed Name _____

Signature _____

Title _____

Date _____

VERIFICATION OF OTHER STATE LICENSE FOR A RADIOGRAPHER LICENSE

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 send 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 send this form directly to the Maryland Board of Physicians at the above address.

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

 Title of Authorized Official

 Signature of Authorized Official

 Direct Telephone Number

 Printed Name of State

 Date

