

Medical Radiation Technology Verification of Education for Temporary Registration

Instruction to Applicant:

Upon completion of the demographic information and waiver below, this form should be signed, notarized, and sent to the Institution where you obtained your degree in Medical Radiation Technology.

<i>Date</i>		
<i>Name (Last, First, Middle, Initial)</i>		<i>Maiden Name or Given Surname</i>
<i>Address (Street, City, State and Zip Code)</i>	<i>Phone Number</i> ()	<i>Home</i> () <i>Work</i> ()
<i>Social Security Number</i>	<i>Date of Graduation</i>	

Waiver for the Release of Information:

I am applying for a temporary registration as a Medical Radiation Technologist in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure - Rad Tech, should this information be requested at any time.

Subscribed and sworn to before me this day of _____ 20 ____.

My commission expires _____ 20 ____.

Notary Signed

Seal

Date

Signed

Instructions to Educational Institution:

Upon completion of this form please send to: Mississippi State Department of Health
Professional Licensure – Medical Rad Tech
Post Office Box 1700
Jackson, Mississippi 39215-1700

<i>Name of Institution</i>	<i>Location of Institution (City & State)</i>
<i>Dates of Attendance (Month/Year)</i> From: To:	<i>Total Number of Academic Years</i>
<i>Dates Degree Conferred, or, Expected Date</i>	<i>Degree Conferred, or, to be Conferred</i>
<i>Program Name & Curriculum Description</i> <i>Is this applicant eligible to sit for the ARRT or NMTCB Examination</i> ☐ Yes ☐ No	

Seal of the Institution

Name

Title

Telephone Number