Joe Lombardo
Governor

Laura Rich,
Director

DEPARTMENT OF HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Andrea R. Rivers,
MS
Administrator

Ihsan Azzam,
Ph.D., M.D.,
Chief Medical Officer

Rural Authorization Registration Form

A person who does not hold a license or limited license may take X-ray photographs under the supervision of a physician or physician assistant as part of his or her employment or service as an independent contractor in a rural health clinic or federally-qualified health center pursuant to NRS 653.620 if they:

(a) Submits this form to Register or Renew Registration with the Division.
(b) Submits to the Division a signed "Attestation of Employee Training" section below in radiation safety and proper positioning for X-ray photographs provided by the holder of a license.
(c) Submits to the Division a signed "Attestation" form confirming knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.
(d) Submit to the Division proof that the person will be employed or serve as an independent contractor in a rural health clinic or federally-qualified health center that has established a quality assurance program for X-Ray photographs, per NAC 653.090.
(e) If renewing registration, submits proof of completing 20 continuing education credits relating to category A or A+, by an approved National Professional Organization.

Please select the appropriate scope of practice that this application is for: (check all that apply)

☐ Chest ☐ Extremity ☐ Spine ☐ Skull/Sinus ☐ Foot/Ankle ☐ Bone Densitometry

Select below the facility type where employed, and if the facility has established a quality assurance program as indicated. If working at more than one location, list each employer separately and attach.

☐ Federally-qualified health center. Pursuant to 42 U.S.C. § 1396d(l)(2)(B).

☐ Rural health clinic. Pursuant to 42 U.S.C. § 1395x(aa)(2).

Applicant's First Name	Last Name	MI.	SSN or APIN:[1]

Street Address	City	State	Zip Code

Current Employer, if applicable

Employer's Address	City	State	Zip Code

Phone Number	Fax Number	Email Address

[1] Required pursuant to NRS 622.238(3) and 653.550(1)(a).

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675 Fairview Drive, Suite 218 ● Carson City, NV 89701 ● (775) 687-7550 ● Fax (775) 687-7552 ●
radiationcontrolprogram@health.nv.gov ● dpbh.nv.gov/Reg/Radiation_Control_Programs/

ALL IN GOOD HEALTH.

APPLICANT ATTESTATION

I,_____, attest that I am the person described and identified in this application; that I have answered all questions in this application truthfully and completely; that any furnished supporting documentation is accurate to the best of my knowledge. I understand that prior to making a determination regarding my application, the Division may require additional information from me.

Signature:_____Date: _____

EMPLOYEE TRAINING ATTESTATION

⇨ ***This section below must be completed by either a Physician, licensed Physician's Assistant (PA-C) or licensed Radiologic Technologist who has personally worked with the applicant.***
The signee below must hold a license issued by the Division for the modality indicated, or hold appropriate credentials, or have direct experience to verify the applicant's scope of practice or duties.
Submit a copy of any documentation or information used to verify the training of the applicant. Submit a copy of your license, any credentials, or describe your direct experience based on the modality verified.

I attest the applicant has completed training in radiation safety and proper positioning for X-Ray photographs, pursuant to NRS 653.620 (1)(b), in the modalities indicated above.

I have the following license or registration (mark):

Physician: ☐ **Physician's Assistant:** ☐ **Radiologic Technologist:** ☐

Attestor's Name:_____Title: _____
(Printed)

Attestor's Signature_____Date: _____

Attestor's License number:_____

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