

LICENSE VERIFICATION FORM

FLORIDA DEPARTMENT OF HEALTH
EMT/PARAMEDIC/RADIOLOGIC TECHNOLOGY OFFICE
4052 BALD CYPRESS WAY, BIN C85 - TALLAHASSEE, FL 32399-3285
(850) 245-4910 - (850) 921-6365 FAX

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE APPLICANT WHO ANSWERS "YES" TO QUESTION "D" ON PAGE 3 OF THE RADIOLOGIC TECHNOLOGIST APPLICATION (FORM 1005). AFTER COMPLETION, THE APPLICANT IS TO MAIL THIS FORM TO EACH ORGANIZATION WHERE HE/SHE HOLDS OR HAS HELD A LICENSE, REGISTRATION OR CERTIFICATE TO PRACTICE RADIOLOGIC TECHNOLOGY OR OTHER HEALTH PROFESSION.

I, _____ HOLDING LICENSE/CERTIFICATE/REGISTRATION NUMBER _____, ISSUED BY
APPLICANT'S FULL NAME (PRINT) NUMBER
_____, HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE ALL INFORMATION CONCERNING ME,
VERIFYING ORGANIZATION
FAVORABLE OR OTHERWISE, DIRECTLY TO THE FLORIDA DEPARTMENT OF HEALTH, RADIOLOGIC TECHNOLOGY PROGRAM.

APPLICANT'S SIGNATURE DATE

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE VERIFYING ORGANIZATION, WHICH SHOULD MAIL THIS VERIFICATION DIRECTLY TO THE DEPARTMENT ADDRESS ABOVE. PLEASE USE AN ADDITIONAL SHEET IF NEEDED FOR ANY RESPONSE. QUESTIONS SHOULD BE DIRECTED TO DEPARTMENT PERSONNEL AT THE PHONE NUMBER LISTED ABOVE.

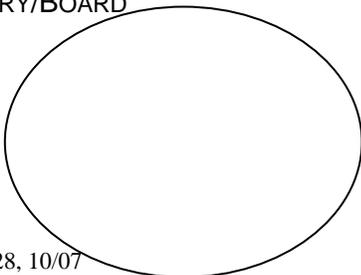
LICENSE/CERTIFICATE/REGISTRATION NUMBER _____ WAS ISSUED ON _____ AND EXPIRES ON _____.
IS THIS LICENSE/CERTIFICATE/REGISTRATION CURRENT? ___ Yes ___ No IF NO, PLEASE EXPLAIN.

HAS YOUR ORGANIZATION EVER REVOKED, SUSPENDED, SURRENDERED, RESTRICTED, PLACED ON PROBATIONARY STATUS OR PUT UNDER INVESTIGATION THIS LICENSE/CERTIFICATE/REGISTRATION? ___ Yes ___ No IF YES, PLEASE EXPLAIN.

HAS YOUR ORGANIZATION EVER BROUGHT ANY DISCIPLINARY CHARGES AGAINST THIS PERSON? ___ Yes ___ No IF YES, PLEASE EXPLAIN.

DOES YOUR ORGANIZATION PRESENTLY HAVE ANY LEGAL ACTION/COMPLAINTS PENDING AGAINST THIS PERSON? ___ Yes ___ No IF YES, PLEASE EXPLAIN.

NOTARY/BOARD
SEAL



DH 4128, 10/07

NAME (PLEASE PRINT)

SIGNATURE

VERIFYING ORGANIZATION

DATE