



Nuclear Medicine Technology Certification Board Application for PET Specialty Examination

NMTCB
3558 Habersham at Northlake
Building I
Tucker, GA 30084
404-315-1739 / FAX: 404-315-6502
board@nmtcb.org

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- Instructions:**
1. Read all instructions first.
 2. Print or type all responses, except where signature or initials are required.
 3. Enclose a check or money order in the amount of \$225.00 payable to the NMTCB.

Exam Date: The NMTCB PET exam is available on demand and may be taken any time within six months of application approval.

Testing Locations: The PET specialty exam will be administered nationally by IQT, Inc. More information regarding testing centers will be emailed to you.

Name and Address Information:

24 VOICE credits awarded to SNM members upon passing the PET exam.
SNM Member number _____

I am applying for the NMTCB PET Examination

Name: Mr. _____
 Ms. _____
 Dr. _____
First Middle Initial Last

Address: _____
Street Address Apt. # City State Zip

Telephone (Primary) _____ / _____
Area Code

Social Security Number: _____ - _____ - _____ Date of Birth: _____

E-Mail address _____ @ _____

Please provide a valid email address you check often. This is where you will receive your examination scheduling information so please print clearly.

1. Are you interested in receiving email from professional organizations? Yes No
2. Are you interested in receiving email from commercial organizations? Yes No

(blank responses will be interpreted as "yes")

Complete one of the sections below:

Nuclear Medicine Certification:

Please check the appropriate box below and fill in your certificate number. Only one of the certifications below are needed. Enclose a copy of your current certification card.

- NMTCB Certificate Number _____
(Specialty Exam ID _____)
NMTCB certification status must currently be *Active*.
- ARRT(N) Certificate Number _____
- CAMRT nuclear medicine Certificate Number _____

Other Certification:

Please check the appropriate box below and fill in your certificate number. Only one of the certifications below are needed.

- ARRT(R) Certificate Number _____
- ARRT(T) Certificate Number _____

Enclose a copy of your current ARRT registration card.

Indicate other certifications that you have (ex. ARRT(CT)):

Coursework Report Sheet:

This report sheet must be completed for proper submission of the 45 hours of coursework (or 45 Continuing Education Hours) needed for Non-Nuclear Certified applicants. Enclose documentation for each course. Please submit information specifically pertaining to the required three categories only: Nuclear Medicine Instrumentation, Radiopharmacy, and Radiation Safety. A minimum of 15 hours in each of these three areas is required, for a total of 45. Complete this section, and then continue to page 3, bottom. Print extra copies of this page if required.

	Course Title	Documentation		Number of hours
		Enclosed	Date	
Instrumentation	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
				Total: 15
Radiopharmacy	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
				Total: 15
Radiation Safety	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
	_____	<input type="checkbox"/>	_____	_____
				Total: 15

Copy this page as needed.

Clinical Experience – Nuclear Medicine Technologists:

Certified Nuclear Medicine Technologists: List your clinical PET experience in reverse chronological order, beginning with current employer. A minimum of 700 hours experience on a dedicated PET and/or PET/CT scanner is required. **Please print clearly.** Copy this page if you need to list more places of employment.

Institution/Company Name

Institution/Company Mailing Address

Name of Supervising Physician

Radiologist Nuclear Medicine Other

Physician's Email

Physician's fax number

Name of Supervisor/Manager

Supervisor/Manager's Email

Supervisor/Manager's fax number

Is above address correct to reach supervisor? Yes No (if no, please indicate correct address here):

Dates Employed - From (mm/dd/yyyy)

To (mm/dd/yyyy)

Indicate PET employment status: Full-Time Part Time Other _____

Clinical Experience - RT(R) or RT(T):

RT(R)'s or RT(T)'s: List your clinical PET experience in reverse chronological order, beginning with current employer. Minimum requirement is 700 hours of clinical experience performing all aspects of PET imaging including radiopharmaceutical handling, injection (if permitted by state and/or institutional regulations) and imaging. Imaging may be performed on a PET and/or a PET/CT scanner. Supervision and direct supervision must be performed by a nuclear medicine physician or radiologist **AND** a certified NMTCB, ARRT (N) or CAMRT technologist respectively. **Please print clearly.** Copy this page if you need to list more places of employment.

Institution/Company Name

Institution/Company Emailing Address

Name of Supervising Technologist

CNMT ARRT(N) CAMRT

Supervisor's Email

Supervisor's fax number

Is above address correct to reach supervisor? Yes No (if no, please indicate correct address here):

Name of Supervising Physician

Radiologist Nuclear Medicine Other

Physician's Email

Physician's fax number

Is above address correct to reach physician? Yes No (if no, please indicate correct address here):

Dates Employed - From (mm/dd/yyyy)

To (mm/dd/yyyy)

Indicate PET employment status: Full-Time Part Time Other _____

Ethics Questions:

Have you ever:

- a. been charged with or convicted of a misdemeanor (other than a minor traffic offense) or felony or general court martial in military service, and/or are any such charges currently pending against you? ___Yes ___No
- b. had any professional license, registration, or certification application denied, or any issued license, registration, or certification revoked, suspended, placed on probation, or subject to any type of discipline by a regulatory authority or certification board? ___Yes ___No
- c. been found by any court or administrative body to have committed negligence (simple or willful), malpractice, recklessness, or engaged in misconduct in the practice of any profession? ___Yes ___No
- d. been terminated from an employment position involving the use of NMTCB credentials and where the conduct leading to such termination has involved: child or elder abuse, sexual abuse, substance abuse, job-related crimes, violent crimes against persons? ___Yes ___No

If you answered yes to any question above, you MUST attach an explanation and, if appropriate, a certified copy of the final decree.

Attestation and Statement of Applicant:

I understand that the NMTCB reserves the right to require a national criminal background check, at my expense, through a source and under conditions determined by the NMTCB. The NMTCB shall provide me with a reasonable notice and period of time to complete this background check. I hereby grant the NMTCB to perform a national criminal background check should they deem it appropriate. _____**please initial**

I have read, am in compliance with, and agree to continue compliance with all of the NMTCB's rules and regulations, as may be revised from time to time by the NMTCB, including, but not limited to, the NMTCB eligibility requirements, disciplinary and appeal procedures, certification, annual renewal, fees, ethics standards, and continuing education policy. _____**please initial**

I understand that any intentional or unintentional failure to provide true and complete responses to this application may result in denial of my application for certification or disciplinary action by the NMTCB. _____**please initial**

I authorize the NMTCB to confirm the information contained in this application and allow the NMTCB to request information related to my education, employment, relevant personal history, and professional license, registration, or certification. _____**please initial**

I hereby make application to the Nuclear Medicine Technology Certification Board, Inc. (NMTCB) for examination in the specialty of PET in accordance with and subject to NMTCB rules and regulations adopted from time to time. I understand and agree to be bound by all rules and regulations adopted by the NMTCB.

I have enclosed the nonrefundable fee of \$225.00 by credit card, check or money order payable to the NMTCB. I understand that the application fee is nonrefundable and that, once my application is approved, I am required to make an appointment and appear for the examination within six calendar months of the date that appears on the eligibility approval letter. I also understand that if I fail to make an appointment during the eligibility period, I may extend the eligibility period by an additional six calendar months one time for a fee of \$50.00 USD.

I understand that I must contact the NMTCB office immediately if circumstances make it impossible for me to appear on the date scheduled. I also understand that candidates who fail to appear on the date scheduled or fail to change their scheduled appointment more than 96 hours in advance, may reschedule within the same eligibility period for a fee of \$112.50 USD and candidates who fail to appear on the date scheduled and wish to extend the eligibility period by an additional six calendar months one time may do so for a fee of \$150.00 USD.

I understand that if I fail to sit for the exam within one calendar year of eligibility approval, I will be required submit the full application fee in order to reactivate the application and be considered eligible.

I hereby submit this application and supporting documents and attest to the authenticity and accuracy of the application and all information contained herein. I also understand that, in the event that any information contained in this application or supporting document: 4 of 5 my

behalf, is determined by the NMTCB to be false or misleading, this application may be denied, entrance to the examination may be refused, examination score withheld or invalidated, and any other remedy available to the NMTCB, including adverse action against any already issued NMTCB certification. NMTCB also reserves the right in its sole discretion to turn such information over to state or federal administrative or criminal authorities.

I agree to abide by all NMTCB policies and procedures related to the application and certification process. I hereby recognize the NMTCB owned intellectual property rights including the examination and its processes and agree to maintain the confidentiality of these copyrighted materials. I further understand that giving aid to or receiving aid from any third parties in taking this examination or advising any third parties of any of the questions or answers orally, in writing or through any media before, during or after the examination or other misuse of the NMTCB materials protected under intellectual property laws will be sufficient cause for the NMTCB to deny my application, withhold or invalidate my examination score, disqualify me from reexamination, impose an adverse action against an already issued NMTCB certificate, and any other remedy available to the NMTCB, including civil and criminal remedies under applicable laws.

I declare that I have examined this application and, that to the best of my knowledge and belief, the statements contained herein are true, correct and complete. I authorize representatives of the NMTCB to verify the accuracy of any information contained in this application from any persons having knowledge of such information. It is my intent that this acknowledgment and authorization act as a release to all entities, including educational institutions, professional organizations, and/or employers, regarding the disclosure directly to NMTCB of all relevant information for purposes of processing my application.

I understand that the application, all information contained therein and any supporting documents submitted on behalf of the applicant are the property of the NMTCB and may be used for any purpose within the mission of the NMTCB.

I agree and promise to hold the NMTCB and its members, agents, officers and committee members harmless from any damages or loss, monetary or otherwise, incurred by reason of any action taken by NMTCB in this application process including, but not limited to, the refusal to issue or recognize an examination score, refusal to issue NMTCB certification, or removal of NMTCB certification.

I certify that I am the candidate whose signature appears below and agree to supply any other documentation designed to ensure my identification and maintain the integrity of the application NMTCB process.

Signed

Date

Be advised that your signature on this document constitutes your agreement with the statements in this application

Payment

I have enclosed a check or money order for \$225.00

Please charge my MasterCard, Visa or Discover \$225.00

Credit Card Info (Visa, MasterCard or Discover only):

Card Number _____ Expiration Date _____

Name _____ 3-digit verification # _____
(as it appears on card) (from back of credit card)

**Mail this application to
NMTCB • 3558 Habersham @ Northlake • Building I • Tucker, GA • 30084**