MISSISSIPPI STATE DEPARTMENT OF HEALTH

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.

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

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.

_____ _____
Date Signed

Instructions to Educational Institution:
Upon completion of this form please send to:

Mississippi State Department of Health
Professional Licensure - Rad Tech
Post Office Box 1700
Jackson, Mississippi 39215-1700

Name of Institution	*Location of Institution (City & State)*
Date Degree Conferred	*Degree Conferred*
Program Name & Curriculum Description *Is this applicant eligible to for the ARRT or NMTCB Examination* *Yes No*	

_____
Name

Seal of the Institution

_____
Title

_____
Telephone Number