



TEXAS MEDICAL BOARD

APPLICATION FOR SUPERVISION OF A NON-CERTIFIED RADIOLOGIC TECH

NON-CERTIFIED RADIOLOGIC TECHNICIAN (PLEASE PRINT)		
_____	_____	_____
Last Name	First Name	Middle Name
_____	_____	
Texas NCT Permit Number (Do NOT enter TDSHS)	Social Security Number	
Technician performs bone densitometry only. <input type="checkbox"/> (Please note that leaving this box blank is an indication that the technician is performing radiologic procedures other than bone densitometry.)		
SUPERVISING PHYSICIAN (PLEASE PRINT)		
_____	_____	_____
Last Name	First Name	Middle Name
_____	_____	
Texas License Number	Supervision Begin Date	
TERMINATION OF SUPERVISORY RELATIONSHIP		
I am submitting this form to notify the Board that my relationship with the NCT named above has been or will be terminated.	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
		Termination Date
OATH		
I hereby certify that I am the person named in this application to supervise a non-certified radiologic technician in the state of Texas, that all statements I have made herein are true, and that the radiologic technician will function under my supervision and responsibility.		
_____	_____	_____
Supervising Physician's Signature		Date

Location Address:
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

Mailing Address
P.O. Box 2029
Austin, Texas 78768-2029
www.tmb.state.tx.us

Phone 512.305.7030
Fax 888.790.0621
Licensure Fax 888.550-7516