

**\*SPECIAL RENEWAL APPLICATION**

\* This form is for use **only** by those who did not receive their renewal billing notice 45 days before their expiration date.

**California Nuclear Medicine Technology Certificate**

<b>Number of Scopes Issued</b>	Certificate Number	Certificate Expiration Date
Last Name, suffix	First Name	Middle Name
Date of Birth	Social Security Number	Phone Number
Mailing Address <input type="checkbox"/> Check this box if this is a change of address since your last certificate/permit was issued.		
City	State	ZIP Code

**It is very important that you provide your full true name.**

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. For information or access to your records, contact the Chief of the Certification Unit at the California Department of Public Health, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

Return this form along with your applicable nonrefundable renewal fee payment in the form of a check or money order made payable to **“CDPH-RHB”** (*California Department of Public Health – Radiologic Health Branch*):

- \$175.00** if your certificate has not expired.
- \$218.75** if your certificate has expired.

REQUEST FOR CANCELLATION

I do not wish to renew one or all of my certificate(s) or permit(s). Cancel the following certificate or permit: \_\_\_\_\_

Attach documentation that establishes your participation in management sponsored or formal continuing education offered by professional organizations or societies or institutions of higher learning. This education and training is required to be of at least five clock hours in each of the scopes for which your certificate was issued since your last certificate renewal or initial application.

Include your nonrefundable fee payment with attachments and mail this form to:

**Billing and Cashiering Unit  
California Department of Public Health  
Radiologic Health Branch, MS 7610  
P.O. Box 997414  
Sacramento, CA 95899-7414**

*I certify that all information provided with this application is true and correct. I understand that the California Department of Public Health may cancel certificates that are procured by fraud, misrepresentation, or mistake, and may revoke certificates for the nonpayment of fees. Further, I am aware that it is unlawful to use X-rays on human beings in this state unless I am certified pursuant to the Radiologic Technology Act, I am acting within the scope of that certification, and I am acting under the supervision of a licentiate of the healing arts who is a certified supervisor or operator.*

Signature	Date
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