

Please Do Not use this Renewal Application if your certificate expires on or after January 31, 2015

***SPECIAL RENEWAL APPLICATION**

* This application 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

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

It is very important that you provide your full true name. Pursuant to the California Code of Civil Procedure Section 1275, name change requests must be accompanied by a copy of a certified superior court order allowing the name change and a government issued picture ID, such as a driver’s license, military ID, or passport.

Return this application along with your applicable nonrefundable renewal fee payment in the form of a check or money order made payable to “**CDPH-RHB**” for:

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

A valid temporary authorization will be available to view and print for work purposes, within 24-48 hours after your renewal is processed, at <http://rhbxray.cdph.ca.gov/>.

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. You are required to maintain the documents for four years so that you can make them available to the Department upon request.

Include your **nonrefundable** fee payment with attachments and mail them with this application to:

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

Overnight/express mail (USPS, FedEx, etc.) must be sent to:
Billing and Cashiering Unit
CDPH-RHB
1500 Capitol Avenue, Suite 520,
MS 7610, Bldg. 172
Sacramento, CA 95814-5006

<p>REQUEST FOR CANCELLATION <i>Please note: If you request to cancel your certificate, you are not eligible for reinstatement and will need to reapply for a new certificate.</i></p> <p><input type="checkbox"/> I wish to cancel one or more of my certificate scopes. Please cancel the following certificate scopes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diagnostic in vivo & in vitro tests including venipuncture (no imaging) <input type="checkbox"/> Imaging including venipuncture <input type="checkbox"/> Generators and reagent kits <input type="checkbox"/> Internal radioactive material therapy <p><input type="checkbox"/> I wish to cancel ALL of my authorized scopes.</p>
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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 radiopharmaceuticals on human beings in this state unless I am certified pursuant to the laws pertaining to nuclear medicine technology, I am acting within the scope of that certification, and I am acting under the supervision of a nuclear medicine physician.

Signature	Date
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