Renewals will not be considered complete until both the renewal payment and continuing education credits have been received by the department.

Nuclear Medicine Technologist Renewal Check List:

1. Renewal Payment:

Return the completed Special Renewal Application (page 2) along with your **nonrefundable** renewal payment in the form of a check or money order made payable to "**CDPH-RHB**". The fees are as follows:

$261.00 if your certificate has not expired.
$326.25 if your certificate has expired.

2. Continuing Education Credits:

- 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.

For further information on continuing education credit requirements, you may visit RHB Continuing Education Credits Requirements Page . Failure to provide a complete renewal, will delay the update of your certificate.

You are required to maintain proof of continuing education for four years, to be provided upon request.

3. Mail your renewal payment and continuing education credits to:

Mailing Address:
CDPH-Radiologic Health Branch
Billing/Cashiering, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

Express Mail:
CDPH-Radiologic Health Branch
Billing/Cashiering, MS 7610
1500 Capitol Avenue
Sacramento, CA 95814-5006

A valid temporary authorization will be available to view and print for work purposes, within 24-48 hours after your completed renewal is processed, at RHB Certificate/Permit Search Tool .

SPECIAL RENEWAL APPLICATION
California Nuclear Medicine Technology Certificate

Certificate Number	Certificate Expiration Date	Phone Number
Last Name, Suffix	First Name	Middle Name
Social Security Number / ITIN	Date of Birth (MM/DD/YYYY)	Email Address
Mailing Address or P.O. Box Number ☐ Check if you are requesting to change your address		
City	State	Zip Code

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. The information you provide on this form may be made public by the California Public Records Act; please provide a P.O. Box number or other alternate address and/or an alternate phone number if you do not wish to have your home address and/or phone number made public.

REQUEST FOR CANCELLATION (optional)

Please note: If you request to cancel your certificate or scope(s), you are not eligible for reinstatement and will need to reapply for a new certificate or scope(s).

☐ I wish to cancel one or more of my certificate scopes. Please cancel the certificate scopes:

- ☐ Diagnostic in vivo & in vitro tests including venipuncture (no imaging)
- ☐ Imaging including venipuncture
- ☐ Generators and reagent kits
- ☐ Internal radioactive material therapy

☐ I wish to cancel **ALL** of my authorized scopes. (Do not submit payment)

I certify that the information provided in this application for renewal 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 (Original Signature Required)	Date