UPDATED INFORMATION FORM

(Please Print)

UPDATE RECORDS FOR:	
Check all that apply:	☐ New Employer ☐ New Supervising Physician ☐ New Name ☐ New Address

LICENSEE INFORMATION				
Last name:	First:	Middle:	Maiden/Other:	
Street address:		Social Security no.:	Home phone no.: ( )	
P.O. box:	City:		State:	ZIP Code:
Email:			Cell phone no.: ( )	

EMPLOYER INFORMATION			
Employer:			
Street address:			Facility phone no.: ( )
P.O. box:	City:	State:	ZIP Code:
Supervisor:			Facility Fax no.: ( )

SUPERVISING PHYSCICAN INFORMATION
(Not Required for Permanent Radiologic Technologists)
I certify that ___________________________ will be under my supervision while practicing radiologic at the facility above.
Physicians Signature:
Physicians Printed Name and Title (DC, DPM, MD, etc.):

I declare that the above information is true to the best of my knowledge.

✔ ***Licensee Signature*** ✔ ***Date***

RETURN FORM TO: FAX: (971) 673-0218 OR OBRT
800 NE OREGON ST, SUITE 1160A
PORTLAND OR 97232

Revised January 2009