



OREGON BOARD OF MEDICAL IMAGING
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LXMO

Supervising Form

Include this form with Online Application or Renewal in the appropriate section.

Supervisor: Licensed Physician, Nurse Practitioner, Physician Assistant

I hereby certify that,

LXMO Applicant's Name

will be under my supervision while practicing medical imaging at the facility (employer) listed in this application.

Supervisor's Signature

Supervisor's Printed Name

Title

Date