UPDATED INFORMATION FORM

➤ **Update records for:** [check all that apply]: ❑ License ❑ Limited Permit ❑ Temporary Permit
☞ New Address ❑ ☞ New Name ❑ **(Provide Proof – Drivers License, Marriage, or Court Document)**

EMPLOYEE INFORMATION

NAME_____
Last First Middle Maiden/Other

ADDRESS_____
Street or Post Office Apt # City State Zip

PHONE _____ **SOCIAL SECURITY #**_____

EMPLOYMENT INFORMATION

➤ **Notification of**: ❑ New Employer ❑ 2nd Employer ❑ Additional Location

EMPLOYER_____

ADDRESS_____
Street or Post Office Apt # City State Zip

Beginning employment date_____**Work Phone**_____

SUPERVISING PHYSICIAN'S SIGNATURE
(NOT REQUIRED FOR PERMANENT LICENSED RADIOLOGIC TECHNOLOGISTS)

➤ The signature, name & title of physician responsible for your x-ray work is required.

I certify that _____ will be under my supervision while practicing radiologic technology at the facility listed above.

_____ _____
Physician's Signature *Date*

_____
Physician's printed Name and Title (DC, DPM, MD, etc.)

EMPLOYEE SIGNATURE

➤ I declare that all information on this form is accurate and true to the best of my knowledge.

_____
Signature of Employee *Date*

RETURN FORM TO: FAX: 971-673-0218 OR OBRT
800 NE OREGON ST
PORTLAND OR 97232-2162

Revised February 2003