RADIOLOGY SUPPLEMENTAL QUESTIONNAIRE

I practice the following:

☐ Diagnostic Radiology ________% of practice

☐ Interventional Radiology ________% of practice

☐ Therapeutic (Oncological) Radiology ________% of practice

☐ Neuroradiology ________% of practice

Do you practice telemedicine? ☐ Yes ☐ No

If yes, please provide detailed information below regarding with whom you contract and locations.

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Do you read or interpret diagnostic imaging films (e.g., CT scans, MRIs, mammograms, ultrasound films, x-rays) from outside of the state in which you reside? ☐ Yes ☐ No

If yes, please provide detailed information below regarding with whom you contract, list of states where the imaging films originate and license number.

State: ____________________ License #: ____________________

State: ____________________ License #: ____________________

State: ____________________ License #: ____________________

Please indicate if you perform, read or interpret any of the following:

☐ X-rays

☐ CT scans

☐ MRI

☐ Mammograms

☐ Ultrasound Films

☐ Fluoroscopy

☐ Embolization

☐ Stents

☐ Biopsy

☐ Brachytherapy

☐ Radiofrequency Ablation

☐ Angiography

☐ Angioplasty

SIGNATURE REQUIRED:

X ____ ____________________

Applicant Signature Date

Type or print name and title:

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