New Jersey Department of Environmental Protection
Bureau of X-ray Compliance
PO Box 420 Mail Code 25-01
Trenton, New Jersey 08625-0420
Phone: (609) 984-5890 Fax: 609-984-5811
www.xray.nj.gov

Instructions for use of the Clinical Affiliate Application and Curriculum Completion Statement

Please type or print information clearly. If information is illegible, the application will be returned.

1. The school will give this form to the clinical facility to complete the Clinical Affiliate Application sections 1-4. If more than one office will be used for clinical education, than a form must be completed for each office. **Important Notes to the Clinical Facility:** X-ray facility ID and machine registration information can be obtained from Bureau of X-ray Compliance (Bureau) by calling 609-984-5370.

   A student can engage in the practice of dental radiologic technology which includes positioning patients, selecting exposure factors, and making x-ray exposures only during the time that the school's permission is given. Once the clinical requirements are completed or the permission period is expired, the student is not permitted to engage in the above activities until issued a licensed by the Department of Environmental Protection.

   The school's permission period is limited and cannot be extended without the written permission of the school.

2. After the student has successfully completed the didactic and laboratory requirements of the program, the school must complete the "Verification of Didactic and Laboratory Completion" statement and forward this form to the Bureau for review and approval.

3. The Bureau will review the Clinical Affiliate Application for compliance with the Radiologic Technology Board of Examiners' Standards. The Bureau will approve or deny the clinical affiliate application and return to the school within five business days.

4. If the application is approved, the school will complete the "Permission Statement", maintain a copy in the student's file and provide this form and the Clinical Competency Evaluation Forms to the clinical facility to track the student's progress in clinical education.

5. Once the student has completed the clinical requirements of the school, the form and all clinical competency evaluation forms are returned to the school for review.

6. If the clinical work has been accepted by the school, the school will sign the curriculum completion statements. A copy of the form is given to the student who will need to submit the form to the Bureau along with a license application.

CLINICAL AFFILIATE APPLICATION AND CURRICULUM COMPLETION STATEMENT

Dental Radiography School Name and ID Number: ______________________________
School fax number: ____________________

Name of Student: ____

1. Clinical Affiliate Site - NJDEP X-ray Facility ID#: ______________

   Facility Name: ____

   Dentist Name: ____

   Address: ____

   City, State, Zip: __________________________ Telephone Number: ____________

2. The following X-ray unit(s) will be used by this student:

	Manufacturer	NJDEP Registration Number
1.	______________________	________________
2.	______________________	________________
3.	______________________	________________

3. **Personnel Supervising Student Technologist** -Please print name, title [i.e., DDS, RDH, RDA, CDA, LRT(D), etc.], and license # as well as the signature of each individual providing student supervision. At least one of the following personnel must provide direct (in-room) supervision at all times:

   ____

   ____

   ____

4. Signature: ______________________ ______________________ __________

   Owner or Co-Owner of this Clinical Facility — Print name — Date

VERIFICATION OF DIDACTIC AND LABORATORY COMPLETION

I verify that the above student has successfully completed the didactic and laboratory requirements of this school's Radiologic Technology Board of Examiners approved dental radiologic technology program.

______________________ ______________________ __________

Signature of Program Director/Instructor — Print Name — Date

BUREAU OF X-RAY COMPLIANCE CLINICAL AFFILIATE REVIEW

Approved ☐ Denied ☐ Date: ________________ Staff Initials: ________

SCHOOL PERMISSION STATEMENT

Permission is given for the above student to start clinical education under the direct (in-room) supervision of at least one of the personnel listed in #3 above.

This permission will expire on: ______________ ______________________ __________

Signature of Program Director/Instructor — Date

CURRICULUM COMPLETION STATEMENT

I certify that the above student has successfully completed all curriculum requirements of this school's Radiologic Technology Board of Examiners approved dental radiologic technology program.

______________________ ______________________ __________

Signature of Program Director/Instructor — Print Name — Date