

**ARKANSAS DEPARTMENT OF HEALTH  
RADIATION CONTROL SECTION  
RADIOLOGIC TECHNOLOGY LICENSURE PROGRAM  
Freeway Medical Building  
5800 W. 10<sup>th</sup> Street, Suite 100  
Little Rock, Arkansas 72204**

**Application for Licensure**

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**Instructions:** Fill out this application in its entirety. This form may be photocopied. Please type or complete legibly using black ink only.

**Note: Do not use "see attached" in lieu of filling out required forms.** Failure to properly complete required forms will delay the processing of your application and may result in its rejection.

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Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(last) (first) (middle)

Home Address \_\_\_\_\_  
(street address) (city) (state) (zip) (county)

Business Address \_\_\_\_\_  
(street address) (city) (state) (zip)

Name of  
Business/Facility \_\_\_\_\_

Home Telephone \_\_\_\_\_ Business Telephone \_\_\_\_\_

**TYPE OF LICENSE** (Check all that apply and see definition page to help you decide)

Registered Technologists must include a copy of your current registry card along with your application.

Radiologic Technologist Licensure (ARRT) (R)(CT)(M) Registry Number \_\_\_\_\_

Radiation Therapy Licensure (ARRT) (T) Registry Number \_\_\_\_\_

Nuclear Medicine Licensure (ARRT, NMTCB) Registry Number \_\_\_\_\_

Limited Specialty License (RCIS) Credentialing ID# \_\_\_\_\_

Limited Licensed Chest Technologist Licensure (Non-ARRT, Non-NMTCB)

Limited Licensed Extremity Technologist Licensure (Non-ARRT, Non-NMTCB)

Limited Licensed Skull and Sinus Technologist Licensure (Non-ARRT, Non-NMTCB)

Limited Licensed Spine Technologist Licensure (ACRRT, Non-ARRT, Non-NMTCB)

Limited Licensed Podiatric Technologist Licensure (Non-ARRT, Non-NMTCB)

Other State Full Radiography, Radiation Therapy or Nuclear Medicine License (fill out Part I at the end of the application and send Part I and Part II to the other state)

Other State Limited Radiography License (fill out Part I at the end of the application and send Part I and Part II to the other state)

**Other State Radiography, Limited Radiography, Radiation Therapy, or Nuclear Medicine License  
(fill out Part I and send Part I & Part II to the other state)**

Name of State	Year Licensed	License Number	Type of License

**Educational Information**

**A.** Have you satisfactorily completed an accredited course of study in one of the following Radiologic Sciences? (Check Appropriate Box Below)

Radiography [ ] Nuclear Medicine [ ] Radiation Therapy [ ]  
Chiropractic Radiologic Technology [ ] Registered Cardiovascular Invasive Specialist [ ]

If yes, complete the following:

Name of Accredited Program /School /College\_\_\_\_\_

Your name at time of graduation\_\_\_\_\_

Date of Graduation\_\_\_\_\_

Program/School/College Address\_\_\_\_\_

Date in which you passed the ARRT, NMTCB, ACRRT, or RCIS\_\_\_\_\_

**HAVE YOU EVER BEEN CONVICTED OF A FELONY?** [ ] Yes [ ] No If yes, please explain and be specific as to what crime was committed, what sentence was carried out and what amount of required rehabilitation was completed including pertinent dates.

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**AGREEMENT**

1. I, the undersigned applicant, recognize the Arkansas Department of Health as the sole and only judge of my qualifications to receive and retain a license issued by the Arkansas Department of Health.
2. If I am licensed, I understand that I must fulfill the professional responsibilities of a Radiologic Technologist or Limited Licensed Technologist and meet the requirements for continuing education credits established by the Arkansas Department of Health.
3. I certify that the statements contained in this application including any attachments or supporting information submitted hereto are, to the best of my knowledge, accurate and I understand that any falsification or misrepresentation of information in this application will be cause for rejection of the application.

Signature:\_\_\_\_\_ Date:\_\_\_\_\_

## Definitions Page

**Radiologic Technologist (Radiographer)** – A technologist who, while under the supervision of a Licensed Practitioner, administers radioactive substances or uses medical equipment emitting or detecting ionizing radiation for human diagnostic or therapeutic purposes, and holds a national certification with the ARRT, obtained through education and examination. Must attach a copy of your current ARRT card along with your application.

**Radiation Therapist** – A technologist, other than a Radiographer or a Nuclear Medicine Technologist, who while under the supervision of a Licensed Practitioner, applies radiation to humans for therapeutic purposes and holds a national certification by the ARRT obtained through education and examination. Must attach a copy of your current ARRT card along with your application.

**Nuclear Medicine Technologist** – A Technologist, other than a radiographer or radiation therapist, who while under supervision of a Licensed Practitioner performs therapeutic, in vivo, imaging, and measurement procedures, prepares radiopharmaceuticals, and administers diagnostic doses of radiopharmaceuticals to human beings and is licensed to possess and use radioactive material, and holds a national certification with the NMTCB, ARRT, or ASCP obtained through education and examination. Must attach a current copy of your ARRT, NMTCB, or ASCP card along with your application.

**Limited Specialty Technologists** – A person, other than a Licensed Practitioner, Radiologic Technologists, or Licensed Technologists, while under the supervision of a Licensed Practitioner, operates medical equipment emitting ionizing radiation for diagnostic purposes on human beings that are limited to specific Invasive Cardiovascular Imaging Procedures, with RCIS credentialing. Must attach copy of CCI-RCIS (Registered Cardiovascular Invasive Specialists) card along with your application.

**Limited Licensed Technologist** – A person, other than a Licensed Practitioner, Radiologic Technologist, or Licensed Technologist, while under the supervision of a Licensed Practitioner, operates medical equipment emitting ionizing radiation for diagnostic purposes on human beings that are limited to specific body parts; Chest, Extremities, Skull/Sinus, Spine or Podiatry and who has successfully passed the ARRT Limited Scope of Practice in Radiography Examination deemed appropriate by the Board, or possesses a American Chiropractic Registry of Radiologic Technologists card. Must attach copy of ACRRT card along with application, or provide other state Limited Scope of Practice in Radiography Examination test scores/result letter and verification of status of other state licensure.

## FEES

**Radiologic Technologist (ARRT, NMTCB)** \$45 for first category and \$20 for additional categories (Not \$20 per category) Copy of current ARRT or NMTCB certification card required. Please specify primary and secondary categories.

Radiography\_\_\_\_\_

Radiation Therapy\_\_\_\_\_

Nuclear Medicine\_\_\_\_\_

Total\_\_\_\_\_

### **Limited Specialty Technologists (RCIS)**

\$45 for the category. Copy of current CCI-RCIS card required.

Registered Cardiovascular Invasive Specialists\_\_\_\_\_

### **Limited Licensed Technologist (ACRRT) or other State Limited Licensed**

\$45 for first category and \$20 for additional categories. (Not \$20 per category) Please specify primary and secondary categories and include copy of (ACRRT) card, if applicable.

Chest\_\_\_\_\_

Extremities\_\_\_\_\_

Skull and Sinus\_\_\_\_\_

Spine\_\_\_\_\_

Podiatry\_\_\_\_\_

**SEND COMPLETED APPLICATION WITH A CHECK OR MONEY ORDER TO:**

Arkansas Department of Health  
Radiation Control Section  
Radiologic Technology Licensure Program  
Freeway Medical Building  
5800 W. 10<sup>th</sup> Street, Suite 100  
Little Rock, Arkansas 72204

**PAGE 4**

**COMPLETE PAGES 5 AND 6 FOR VERIFICATION OF OTHER  
STATE LICENSURE**

**PART I – COMPLETE ONLY IF YOU HOLD A RADIOLOGY LICENSE FROM  
ANOTHER STATE**

**OTHER STATE LICENSE/CERTIFICATE VERIFICATION FORM**

**DO NOT SEND THIS FORM TO THE ARRT, NMTCB, ASCP, OR OTHER NATIONAL CREDENTIALING AGENCY**

**APPLICANT:**

COMPLETE PART I and send PART I and PART II to each state, territory, or country in which you now hold or have ever held any professional radiologic technology license. This form must be sent to the Arkansas Department of Health **DIRECTLY FROM THE VERIFYING AGENCY.** This form does not constitute application for Arkansas Radiologic Technology Licensure.

I hereby authorize the licensing agency of the State/Country of \_\_\_\_\_ to release any and all information on file concerning me, favorable or otherwise, to the Arkansas Department of Health, Radiologic Technology Licensure Program.

\_\_\_\_\_  
PLEASE TYPE OR PRINT YOUR FULL NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
LICENSE NUMBER/ DATE ISSUED/ EXPIRATION DATE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
CITY, STATE, ZIP CODE

**PART II**

**Licensee Name** \_\_\_\_\_

**TO VERIFYING STATE/COUNTRY: PLEASE COMPLETE PART II. RETURN THIS FORM DIRECTLY TO THE ARKANSAS DEPARTMENT OF HEALTH.**

The records of the licensing agency of the State/Country of \_\_\_\_\_ indicate that the above-named individual was issued license/certificate number \_\_\_\_\_ dated \_\_\_\_\_ on the basis of written examination (please name of examination) \_\_\_\_\_; reciprocity with the State of \_\_\_\_\_; other basis (please state) \_\_\_\_\_ . Type of license (radiologic technology, nuclear medicine, radiation therapy or limited license)

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

	Yes	No	Cannot Divulge
1. Is this license/certificate current?			
2. Is this license/certificate a limited or temporary type? (If yes, explain and or remark)			
3. Is this license/certificate in good standing?			
4. Has this individual ever been warned or reprimanded?			
5. Has this individual's license/certificate ever been revoked?			
6. Has this individual's license/certificate ever been suspended?			
7. Has this individual's license/certificate ever been placed on probation?			
8. Has this individual's license/certificate ever been restricted in any manner?			
9. Has this individual ever had any charges filed against him/her?			
10. Do you know of any information that may be a discredit to this person?			
11. Do your files indicate any derogatory information whatsoever?			
12. Does your state use the ARRT for your state licensure testing?			
13. Does your state require at least six hours of continuing education credits a year?			

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Title: \_\_\_\_\_

\_\_\_\_\_  
Name of Licensing Agency

\_\_\_\_\_  
Address of Licensing Agency

\_\_\_\_\_  
City, State, Country, Postal Code

NOTE: Please attach certified copies of any pertinent material such as: Notice of Hearing, Final Decision, Consent Order/Agreement, etc. if the answer to Numbers 1 & 3 is no, or if the answer to 4-11 is yes.

ABOVE SIGNATURE MUST BE NOTARIZED IF THE AGENCY DOES NOT HAVE AN OFFICIAL SEAL.

THE STATE/COUNTRY OF \_\_\_\_\_ SEAL  
COUNTY OF \_\_\_\_\_

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name, is subscribed to Part II of the foregoing instrument, and having by me first duly sworn to oath, acknowledged that he/she had executed the same for the purposes and considerations therein expressed that the foregoing statements are true and correct.

GIVE under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public in and for \_\_\_\_\_ County, \_\_\_\_\_

Notary Signature: \_\_\_\_\_

Printed Name of Notary: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

<p>Return this form directly to:</p> <p>Arkansas Department of Health Radiation Control Section RTL Program Freeway Medical Building 5800 W. 10<sup>th</sup> Street, Suite 100 Little Rock, AR 72204</p>
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