



Radiologic Technology Licensure Program

I, _____ on this date, _____ request
that my ADH/RTL License # _____ be placed on an:

Inactive Status _____

(Check one)

Retired Status _____

Reason for Request:

Thank you,

Sign Here: _____

Fax to: 501-661-2849

or

Mail to: ADH/Radiologic Technology Licensure Program

Freeway Medical Building
5800 W. 10th Street, Suite 401
Little Rock, AR 72204