



ARKANSAS DEPARTMENT OF HEALTH / RADIOLOGIC TECHNOLOGY LICENSURE PROGRAM
Application for Limited Scope of Practice in Radiography Examination

Instructions:

- Please type or complete legibly using black ink only.
- If this form is not completed in its entirety it will not be processed.
- You may download additional applications from our website at— www.healthy.arkansas.gov/rtl.
 - If you are concerned as to what name you should use when registering for this examination, use your driver’s license or passport as a guide.
 - Your **FIRST and LAST** names must match your **valid**, government issued photo ID.
 - If you have changed your name for any reason, update your ID to reflect your correct information, then register with the corrected information.

Please **type or print** your full name: _____
(FIRST) (MIDDLE INITIAL) (LAST)

Complete Address: _____
(STREET) (CITY) (STATE) (ZIP)(COUNTY)

Date of Birth: _____ Social Security Number: _____

E-Mail: _____ Personal Phone _____

Name of Business/Facility _____ Work Phone _____

Work Address _____

Veteran Status: Are you or your spouse a veteran? Yes No

All applicants are required to complete the **Core Module of the Limited Scope of Practice in Radiography Examination administered by the American Registry of Radiologic Technologists.**
The Arkansas State Board of Health ruled that a 70% scaled score would be the passing score for the Limited Scope Examination.

You will not need to retest in a module you have previously passed. *

- There is a 5-year grace period. If you are not licensed within 5 years, retesting is required.

Check all modules in which you desire to test.

- | | | |
|--------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> CORE | <input type="checkbox"/> EXTREMITIES | <input type="checkbox"/> SPINE |
| <input type="checkbox"/> CHEST | <input type="checkbox"/> SKULL/SINUS | <input type="checkbox"/> PODIATRY |



\$140 Testing Fee to be paid directly to the ARRT, **DO NOT** send it with your application.

The RTL Program will mail you a notification letter with further instructions after your application has been processed.

Do not send money with your Limited Scope Examination application.

- *Your application will not be processed.*
- *It will be returned to the sender.*

I, the undersigned, hereby verify that all statements and information contained in this application are true and correct. I hereby verify that I have read and understand all rules and regulations set forth by the Arkansas State Board of Health pertaining to the use of ionizing radiation in the practice of Limited Skeletal radiography and the operation of Medical X-Ray equipment.

Printed Name: _____ Date: _____

Signature: _____

Questions:

Direct questions to the Radiologic Technologist Licensure Program

Phone: (501)661-2301

email address: radiation.administration@arkansas.gov

SEND COMPLETED APPLICATION TO:

ADH/RTL Program
Freeway Medical Building
5800 W. 10th Street, Suite 401
Little Rock, Arkansas 72204