ARKitANS DEPARTMENT OF HEALTH / RADILOGIC 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.
  o 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.
  o Your FIRST and LAST names must match your valid, government issued photo ID.
  o If you have changed your name for any reason, update your ID to reflect your correct information, then register with the corrected information.

** A valid email address is required

Please type or print your full name: ________________________________
(first) (middle) (last)

Street Address: ________________________________________________

City: __________________ State: ______ Zip: ________

Date of Birth: __________________ SS Number __________________

Phone Number: __________________ ** E-MAIL: __________________

Name of Business/Facility: __________________________________________

Work Address: ____________________________________________________

Work Phone: ___________________________ WORK E-MAIL: ________________

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.

  o You will not need to retest in a module you have previously passed (within five years).
  o 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:

- [ ] CORE
- [ ] CHEST
- [ ] EXTREMITIES
- [ ] SKULL/SINUS
- [ ] SPINE
- [ ] PODIATRY

Staff Use: Date: __________________ Staff Initials: ______ Test #: __________________

CC #: ____________________________ Balance: $ ________________

License Number: __________________ License Type(s): RTL ______/______ Expiration Date: ____________
$150 Testing Fee to be paid directly to the ARRT, **DO NOT** send it with your application.

*The RTL Program will email 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:** radiation.administration@arkansas.gov

**Mailing Address:**
ADH/RTL PROGRAM
5800 W 10TH ST STE 401
LITTLE ROCK AR 72204-1704