

# Military Reciprocity Form

## HOW DO I GET AN ARKANSAS LICENSE?

### Military Reciprocity Requirements Summary

- 1) Upon application active duty military personal stationed in the State of Arkansas, a returning military veteran applying within one (1) year of his or her discharge from active duty or a spouse of an active duty military personal or veteran shall be granted automatic licensure to practice medical ionizing radiation exams and its branches under the following requirements:
  - a. Complete the Military Reciprocity Form (this form) and submit along with the following;
  - b. A copy of your current out-of-state license;
  - c. A copy of your social security card;
  - d. A copy of the Sponsors Active Duty Military Orders as required by §17-1-106;
  - e. A copy of your driver's license or other government issued photo-identification license;
  - f. A check or money order for the \$45.00 reciprocity fee. (Fee is non-refundable)
- 2) Applicant must have a **current, valid license** issued under the laws of another state. If you are licensed in another state contact your state board office where you are currently licensed and request that a certification of your licensure record (affidavit) be mailed directly to the Radiologic Technologist Licensure Program.
- 3) When items #1 and #2 are received you will be issued an Arkansas license.

**ARKANSAS DEPARTMENT OF HEALTH**  
**Radiologic Technologist Licensure Program**  
**4815 West Markham, Slot 30**  
**Little Rock, AR 72205**  
**(501) 661-2301**

# Military Reciprocity Form

**Instructions: Please review the reciprocity requirements and process before completing.** When you are ready to complete this form, please do so by printing the information in blue or black ink. This form is required if you were are transferring from another state and you want to become licensed in the state of Arkansas. There is a \$45.00 non-refundable reciprocity fee due at the time you submit this form and the required attachments. This fee does not cover any examination costs.

## Applicant's Name

Last Name		First Name (no nickname)		Middle Name	
Maiden Name (if applicable)		List any other <i>last</i> names you have ever used			
Address		Apt. #	City	County	State Zip Code
Telephone Number ( )		Gender MALE FEMALE		Marital Status	
Social Security Number		Date of Birth		Place of birth (city/state/country)	
Race (circle one): Black White Am. Indian Hispanic Asian Alaskan Native			In what language do you prefer to take the written/state law exam? ENGLISH SPANISH VIETNAMESE KOREAN		

## Licensing Information

What type of license do you currently hold? (circle one)	Radiologic Technologist	Radiation Therapist	Nuclear Medicine Technologist	Limited Specialty Lic.	Limited Scope License
Did you take a national written examination? YES NO If yes circle the exam ARRT NMTCB ACRRRT or CCI			Did you take a limited scope examination? YES NO		
In what state did you take the examination?			Please list <u>all</u> the states that you have held a license.		

## Training Information

What radiography school did you attend?		City/State/County	
Graduation Date		LXMO modules passed: Core Chest Extremity circle all that apply Skull/sinus Spine Podiatry	
What high school did you attend?		City/State/County	
Year Completed		Grade Completed	

## Miscellaneous Information

Has your license been suspended or revoked? If yes, please provide details:
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**Applicant Signature:** By signing this application, I certify that the information provided is correct to the best of my knowledge and that I understand that false statements will be sufficient grounds for the Board to take disciplinary action.

Date	Applicant's Printed Name	Applicant's Signature
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