ARKANSAS DEPARTMENT OF HEALTH / RADIOLOGIC TECHNOLOGY LICENSURE PROGRAM
Application for Registered Technologist Licensure

Instructions:

- **Fill out this application in its entirety**
- **Please type or complete legibly using BLACK INK ONLY**
- **Failure to properly complete the required forms will delay the processing of your application and may result in its rejection.**

Staff Use:

License Type (circle only one): RTL01; RTL02; RTL03; RTLRC

Additional Type (circle all that apply): RTL1A; RTL2A; RTL2B; RTL3A; RTLCT

Customer Number: _____

License Number:_____

Please **type or print** your full name: _____

Street Address: _____

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Phone: _____ E-Mail: _____

Place of Work: _____

Work Address: _____

Work Phone_____

Veteran Status: Circle all that apply Applicant / Spouse

• Active-duty military service members stationed in the State of Arkansas? ☐ Yes ☐ No

• Returning veterans applying within one year of discharge? ☐ Yes ☐ No

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Other State Radiography License (fill out Other State Verification RC FORM 740) and have sent to radiation.administration@arkansas.gov.

Educational Information:

Have you satisfactorily completed an accredited course of study in one of the following Radiographic Sciences? Place a "1" next to your primary license category and the plus (+) symbol in additional categories if applicable.

_____ Radiologic Technology
_____ Radiation Therapy
_____ Nuclear Medicine
_____ Chiropractic Radiologic Technology
_____ Registered Cardiovascular Invasive Specialist
_____ Limited Scope Additional License
_____ Computed Tomography

Name of Accredited Program/School/College: _____

School Address: _____

Your name at time of graduation: _____

Date of graduation: _____

National Certification/Registration Number: _____ Expiration Date: _____

2nd Certification Registration Number if applicable : _____ Expiration Date: _____

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.

_____

_____

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: _____

Questions:
Direct questions to Radiologic Technologist Licensure Program
Phone: (501)661-2301
email address: radiation.administration@arkansas.gov

Primary License Type $45.00

Additional License Type $20.00

Fees not to exceed $65.00

SEND COMPLETED APPLICATION WITH A CHECK OR MONEY ORDER TO:

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