



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—
<https://healthy.arkansas.gov/programs-services/licensing-military-member-licensure-permits-plan-reviews/radioactive-technology-licensure-program/forms-radiologic-technology-licensure/>
 - 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.

**** All fields must be completed**

Please type or print your full name: _____		
(First)	(Middle)	(Last)
Street Address: _____		
City: _____ State: _____ Zip Code: _____		
Date of Birth: _____ SS Number: _____		
Home Phone: _____ Cell Phone: _____		
Primary Email Address: _____		
Name of Training Facility i.e. Clinic/School: _____		
Clinic/School Street Address: _____		
Clinic/School City: _____ State: AR Zip Code: _____		
Clinic/School Phone: _____ Your Work/School Email Address: _____		

Check all modules in which you desire to test:

All applicants are required to pass the **Core Module** which consists of *Patient Care, Safety, & Image Production*.

CORE
 CHEST

EXTREMITIES
 SKULL/SINUS

SPINE
 PODIATRY

Staff Use:	
Date: _____	Staff Initials: _____
CC#: _____	Balance Due: _____
License #: _____	License Type(s): RTL ____/____ 1 st or 2 nd Temporary: _____
Lic. Expiration Date: _____	Test #: _____



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 (within five years).***
- ***There is a 5-year grace period. If you are not licensed within 5 years, retesting is required.***
- The Examination Fee will be paid directly to the ARRT, **DO NOT** send it with your application.

The RTL Program will notify you via email with further instructions **after** your application has been processed.

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

DO NOT email jpeg or tif attachments, or imbedded screen shots of the forms, only email pdf files.

Submit your application by email to: radiation.administration@arkansas.gov

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-OR-

Fax to: 501-661-2849

-OR-

Mail to: Radiologic Technology Licensure Program, 4815 W. Markham St., Slot 30, Little Rock, AR 72205.

For more information regarding Radiologic Technology Licensure visit

<https://healthy.arkansas.gov/programs-services/licensing-military-member-licensure-permits-plan-reviews/radioactive-technology-licensure-program/licensing-information-radiologic-technology/>