RC FORM 700
(08/2020)

ARKANSAS DEPARTMENT OF HEALTH
RADIATION CONTROL SECTION

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.

** 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.

- ***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.***

Check all modules in which you desire to test:

☐ CORE ☐ EXTREMITIES ☐ SPINE
☐ CHEST ☐ SKULL/SINUS ☐ 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