



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

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.

If you're unsure of what category to select call 501-661-2301. If the payment is incorrect your application will be returned to you.

- | | |
|---|--|
| _____ Radiologic Technology (includes CT & Mammo) | _____ Registered Cardiovascular Invasive Specialist |
| _____ Radiation Therapy | _____ Limited Scope Additional License |
| _____ Nuclear Medicine | _____ Computed Tomography (only required for Nuc Med, Rad Therapy) |
| _____ Chiropractic Radiologic Technology | |

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