MEDICAL RADIOLOGIC TECHNOLOGIST CERTIFICATION APPLICATION INFORMATION

PRINT or TYPE all information on the application. Please answer all questions completely, do not leave any blank. Please allow 4 to 5 weeks for processing from the day you mail in your application (even if you mail it overnight). If you do not receive a response from this office after 5 weeks, you may contact us at 512-834-6617 or mrt@dshs.state.tx.us

Please mail application packet to:

Texas Department of State Health Services
Medical Radiologic Technologist Certification
P O Box 12197
Austin, Texas 78711-2197

Put N/A if a particular item is "not applicable". The forms must be postmarked within 30 days after signing.

FEES ARE NON-REFUNDABLE -NO EXCEPTIONS. Make check or money order payable to DSHS.

In accordance with Texas Occupations Code, Chapter 601, (the Medical Radiologic Technologist Certification Act), you cannot perform radiologic procedures until this application is processed and a certificate or temporary certificate is issued. The definition of a radiologic procedure includes any procedure or article intended for use in the diagnosis of disease or other medical or dental conditions in humans (including diagnostic x-rays or nuclear medicine procedures) or the cure, mitigation, treatment, or prevention of disease in humans that achieves its intended purpose through the emission of ionizing radiation.

If you only perform procedures utilizing sonography or magnetic resonance imaging (MRI), certification is not required.

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023, 559.003 and 559.004)

GENERAL CERTIFICATE $86.00 application fee

___ 1. Applicant currently holds or has successfully completed national certification with ARRT as a Registered Technologist.

___ 2. Applicant currently holds or has successfully completed national certification as a Certified Nuclear Medicine Technologist by the NMTCB.

TEMPORARY GENERAL CERTIFICATE $32.00 application fee

___ 1. Applicant **is** a graduate of a JRCRTE accredited program in radiography, radiation therapy, or a JRCNMT accredited program in nuclear medicine technology.

___ 2. Applicant has an expected to graduate letter from an accredited program in radiography, nuclear medicine or radiation therapy **WITHIN 28 calendar days**.

TEMPORARY LIMITED CERTIFICATE $32.00 application fee

___ 1. Applicant is a graduate of a radiologic technology program (limited curriculum) approved by the Department of State Health Services or the Council on Chiropractic Education in the categories checked, as follows:

____ Chiropractic ____ Podiatric ___ Spine ___ Chest ___ Extremities ___ Skull

___ 2. Applicant is expected to graduate within 28 calendar days from a radiologic technology program (limited curriculum) approved by the Department of State Health Services or the Council on Chiropractic Education in the categories checked, as follows:

___ Chiropractic ___ Podiatric ___ Spine ___ Chest ___ Extremities ___ Skull

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LIMITED CERTIFICATE $86.00 application fee

Applicant has successfully passed the ARRT examination for one or more of the following categories. Please **check** the categories which you have **passed** and attach examination paper work with application.

_____ CARDIOVASCULAR CATEGORY

_____ CHEST CATEGORY

_____ CHIROPRACTIC CATEGORY

_____ EXTREMITIES CATEGORY

_____ PODIATRIC CATEGORY

_____ SKULL CATEGORY

_____ SPINE CATEGORY

Budget ZZ124

Fund 124

MEDICAL RADIOLOGIC TECHNOLOGIST CERTIFICATION PROGRAM
P O BOX 12197
AUSTIN, TEXAS 78711-2197
(512) 834-6617

PERSONAL INFORMATION

1. Last Name First Name

2. Middle Name

3. Other Names Formerly Used Birth Date (mm/dd/yy)

4. Mailing Address ____

City ______________________________ State ______________ Zip __________

Telephone Number (INCLUDE AREA CODE)________________ Driver's License # & State__________

5. Social Security # ______-______-______ (Disclosure of a social security number by an applicant is mandatory under the Family Code, Section 231.302 and the Health Insurance Portability and Accountability Act of 1996, Section 221. Social Security numbers are confidential and will be used for identification and reporting purposes required by law)

6. Are you CURRENTLY employed? [ ] No [ ] Yes

Place of Employment

Address

City State Zip

Telephone Number (INCLUDE AREA CODE)

Job Title and Duties (Be Specific)

Date of Employment (Month/Year)

7. Circle ONE number below which matches your PRIMARY employment setting (how you spend MOST of your time).
DO NOT CIRCLE MORE THAN ONE (1) CATEGORY.

1. Diagnostic - Hospital
2. Diagnostic - Physician's Office or Clinic
3. Diagnostic - Other Health Care Facility
4. Dentist's Office
5. Chiropractor's Office
6. Podiatrist's Office
7. Radiology Student
8. Radiology Educator
9. Management - Hospital
10. Management - Radiation Therapy Center
11. Management - Other Health Care Facility
12. Radiation Therapy - Hospital
13. Radiation Therapy - Free-standing Therapy Center
14. Radiation Therapy - Other Health Care Facility
15. Nuclear Medicine - Hospital
16. Nuclear Medicine - Other Health Care Facility
17. Radiologic Consultant - Self-Employed
18. Equipment and/or Product Distribution
19. Not Employed/Not Employed in Radiologic Technology
20. Mobile Unit
21. Imaging with Non-Ionizing Radiation (MRI/Ultrasound)
22. Other ____________________________________

8. WORK HISTORY (LIST LAST JOB FIRST)

FROM Mo. Yr.	TO Mo. Yr.	Total Yrs. Mos.	Job Title and Most Important Duties	Employer's Name and Address

PROFESSIONAL CREDENTIALS

9. Please list all professional credentials you hold, including ARRT and NMTCB.
Are you certified by a national organization (Registry) that attests to your competency as an operator of radiation or radiation emitting equipment? (Check Appropriate box) [ ] Yes [ ] No

If "Yes," list the name of that national organization(s) and your certificate number(s) below

SUBMIT A COPY OF THE CURRENT CERTIFICATION (REGISTRY) CARD WITH THIS APPLICATION FORM.

National Organization	Certificate Number	Type	Issue Date
National Organization	Certificate Number	Type	Issue Date
National Organization	Certificate Number	Type	Issue Date
National Organization	Certificate Number	Type	Issue Date

10. Have you ever held any type of certificate or license issued by the Texas Department of Health?
_____Yes _____ No If yes, please list____.

Have you ever held a radiologic technology certificate or any other license from another U.S. state, territory or District of Columbia, which includes Texas State Board of Medical Examiners, Texas State Board of Chiropractic Examiners, and Texas State Board of Podiatric Medical Examiners? _____ Yes ______ No If yes, please list and attach verification from each state, territory or country in which you hold or have ever any professional license.

State/Territory	Title of Certificate or License	Number	Issue Date & Expiration Date

RADIOLOGIC TECHNOLOGY EDUCATION

Applicants who are not recognized as registered/certified technologists by the ARRT, or NMTCB, must submit a copy of a college transcript (transcript must indicate admission as a high school graduate or that a degree was awarded). **Applicants who have not received their diploma or certificate may submit an "expected graduation statement" signed by the program director indicating the anticipated graduation date and the application must be postmarked before the graduation date.**

11. Have you completed a degree at an accredited college or university? (Check appropriate item)
_____ Yes _____ No

If "Yes," check appropriate type.
_____ Associate _____ Bachelor's _____ Master's ____ Doctoral

Your name at time of graduation

Name of College or University

Location of College or University: City State

Year of Graduation

ADDITIONAL INFORMATION

12. Have you ever been denied or surrendered any license or certification or had any certification revoked, cancelled, or suspended?
_______ Yes _______ No If Yes, briefly state the reason(s)____
____

13. Have you EVER pled nolo contendere or been convicted of any crime other than a minor traffic violation?
___ Yes ___ No **If you answered yes to the above question, attach all documentation to include a copy of final disposition or final court orders for all felony and/or misdemeanor offenses (not minor traffic violations). Include any convictions, which are currently on appeal. Discovery of criminal conviction information not disclosed may result in denial of your certification and disclosure of discovered information to other licensing boards.** (DWI is not considered a minor traffic violation).

ATTESTATION

14. READ CAREFULLY---THIS FORM MUST BE SIGNED AND POSTMARKED WITHIN 30 DAYS AFTER SIGNING.

I attest that the statements herein contained are true in every respect. I have read, I understand, and I agree to comply with Texas law and agency rules relating to the certification of Medical Radiologic Technologists and the Registry of Non-Certified Technicians, which are found in Texas Occupations Code, Chapter 601 and Title 25, Texas Administrative Code, Chapter 143. I understand that ALL FEES ARE NON-REFUNDABLE. I understand that additional fees may required to be paid prior to issuance of a certificate. I also understand that additional fees are required in order to renew a renewable certificate. I understand that successful completion of an examination and payment of all fees are required to upgrade a temporary certificate to a renewable certificate.

I agree to notify the department in writing within thirty (30) days of ANY CHANGE of name, address, or place of employment. I agree to return any certificate and identification card to the department upon the revocation, suspension or cancellation of that certificate. I further acknowledge that I am responsible for keeping the certification current in order to perform radiologic procedures on human beings for medical purposes. I agree to comply with the rules relating to renewal, continuing education, and violations and subsequent actions.

Signature of Applicant ____

Date ____

Please note: Any information submitted on the application forms and any supporting documentation is subject to the Public Information Act. This means that anyone requesting copies of the information in your file or requesting to view your file will be able to do so, with the exception of information (such as the social security number) that is confidential by law.

SEND COMPLETED APPLICATION WITH ENCLOSURES AND CHECK OR MONEY ORDER TO:

Texas Department of State Health Services
Attention: MRT Program
P.O. Box 12197
Austin, Texas 78711-2197

TECHNOLOGIST CERTIFICATION PROGRAM
OTHER LICENSE/CERTIFICATE VERIFICATION FORM

DO NOT SEND THIS FORM TO THE ARRT, ARCRT, NMTCB, OR OTHER NATIONAL CREDENTIALING AGENCY

Print or type all information.

Application for certification as a Medical Radiologic Technologist in the State of Texas, requires this form to be completed by all State Boards in which I hold or have ever held a license. My signature below is your authorization to release all information in your files, favorable or otherwise, regarding myself. **Part I to be completed by applicant.**

Applicant's Name ____ Social Security Number ___________________________________

Applicant' s Signature____ Date___________________ License #_______________________

Address____

Telephone Number (include area code)___________________________________ Date of Birth____

PART II. TO BE COMPLETED BY OUT-OF-STATE LICENSING AUTHORITY

State of __________________________________ indicate that the above-named individual was issued license/certificate

No.______________________________ Issue Date ___________________________ Expiration Date _____________________________________

Type of License/Regitration/Certification____

Current status of this License/Registration/Certification is

Active ____ Lapsed____ Inactive_____ Denied*_____ Suspended*____ Revoked*_____

*Please attach a copy of the Findings of Fact and Decision and Order.

License/Registration/Certification based on:

___Education Requirements ____Endorsement/Reciprocity (indicate what state________________________)

___State Examination ____Grandfather Requirements

___National Examination

I certify that the above information is correct and true.

Name of Agency____ Address____

Signature____ Typed Name____

Title____ Date____

(State Seal)

Return this form directly to:

Texas Department of State Health Services
MRT Program
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834-6617