



BUDGET: ZZ124  
FUND: 124

MEDICAL RADIOLOGIC TECHNOLOGIST CERTIFICATION PROGRAM  
PROFESSIONAL LICENSING AND CERTIFICATION DIVISION  
(512) 834-6617

**Information for Applicants for Limited Educational Programs in Medical Radiologic Technology**

**AUTHORITY:** Texas Occupations Code, Chapter 601 and 25 Texas Administrative Code (TAC) §143.9

**PURPOSE:** Determination of Curriculum Qualifications for Independent Sponsors and Sponsoring Institutions.

**INSTRUCTIONS:**

This form **MUST** be completed, signed, dated, notarized and submitted to the Medical Radiologic Technologist Certification Program six (6) weeks prior to providing any instructional services designed to train persons to perform limited medical radiologic procedures and qualify such persons for a temporary limited certificate or limited certificate in medical radiologic technology. The number of students approved by the department will be determined on the basis of the information provided by the applicant.

The applicant shall submit with these completed forms a **CERTIFIED CHECK OR MONEY ORDER** for \$450.00 payable to the Texas Department of State Health Services (DSHS). This fee is **NOT** refundable. A site visit is necessary to approve your application. A site visit fee must be paid and is **NOT** refundable.

Application forms and fees should be sent to:  
DSHS/FUND 124/BUDGET ZZ124  
PO Box 12197  
Capitol Station  
Austin, Texas 78711-2197

Written correspondence **ONLY** should be sent to:  
DSHS/MRT Program  
1100 West 49<sup>th</sup> Street  
Austin, Texas 78756-3183

An original and one (1) copy of the entire application and supporting documentation must be submitted in three-ring binders with all pages clearly legible and consecutively numbered. Each application binder must contain a table of contents and must be divided with tabs identified to correspond with the items listed in §143.9 of the rules adopted by the Board of Health. If any items are inapplicable, a page shall be included behind the tab for that item with a statement explaining the inapplicability.

Narrative material must be typed, double-spaced, and clearly legible. **ALL SIGNATURES OR INITIALS WHERE REQUIRED** on the forms must be an original, not photocopies.

Incomplete notices will be mailed to applicants who do not provide all information requested. If the application is not approvable, the applicants will be notified in writing of the deficiencies and will be given an opportunity to correct them. Applications, which are incomplete, should expect delays or postponement of the program starting date.

If the application is revised or supplemented during the review process, the applicant shall submit an original and one (1) copy of the revision or supplement specified. If a page is to be revised, the complete new page must be submitted with the changed item/information clearly marked.



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PROFESSIONAL LICENSING AND CERTIFICATION UNIT  
MEDICAL RADIOLOGIC TECHNOLOGIST CERTIFICATION PROGRAM  
(512) 834-6617

**Application for limited educational program in medical radiologic technology**

**PART I. GENERAL INFORMATION**

A. Current Date: \_\_\_\_\_ B. Name of Program: \_\_\_\_\_

C. Anticipated Dates of Program: \_\_\_\_\_ (month/year) to \_\_\_\_\_ (month/year)

D. Daily hours: \_\_\_\_\_ a.m./p.m. to \_\_\_\_\_ a.m./p.m. Mon/ Tues/ Wed/ Thurs/ Fri/ Sat

E. Location of Program (include city, state, zip code): \_\_\_\_\_  
\_\_\_\_\_

F. Type of limited curricula (check ALL that apply):

\_\_\_\_\_ Chest \_\_\_\_\_ Skull \_\_\_\_\_ Spine \_\_\_\_\_ Extremities

\_\_\_\_\_ Chiropractic \_\_\_\_\_ Podiatric

G. Type of Program (Check one and complete either Part II or Part III below, whichever applies and Part IV):

\_\_\_\_\_ Independent Sponsor \_\_\_\_\_ Institutional

H. List other education programs conducted (if none, put N/A): \_\_\_\_\_  
\_\_\_\_\_

I. On an additional sheet(s) of paper, provide the following information regarding all medical facilities where students will complete the required clinical instruction and/or clinical experience.

- Name of Facility
- Complete Address of Facility
- Names of certified medical radiologic technologists who will supervise students at each facility
- The information set out in rule TAC §143.9 (c)(6)(E)(i)-(iv)
- Indicate each facilities licensure status and provide copy of license/accreditation certificate

Attach a copy of certificate of registration issued by the Texas Department of State Health Services/Bureau of Radiation Control for x-ray equipment at each facility utilized.

If any of these facilities are utilized by other training programs for clinical instruction of students, indicate name of school or institution and what training programs are conducted.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART II. INFORMATION SPECIFIC TO INDEPENDENTLY SPONSORED PROGRAMS**

A. Sponsor's Name: \_\_\_\_\_

B. Address (include city, state, zip code): \_\_\_\_\_  
\_\_\_\_\_

C. Telephone Number: (between 8 a.m. and 5 p.m.) (\_\_\_\_\_) \_\_\_\_\_ extension \_\_\_\_\_

D. Texas Certificate/License Number: \_\_\_\_\_ Type of Certificate/ License: \_\_\_\_\_

\_\_\_\_\_ Chiropractic                      \_\_\_\_\_ Physician                      \_\_\_\_\_ Podiatrist

\_\_\_\_\_ Medical Radiologic Technologist                      \_\_\_\_\_ Limited Medical Radiologic Technologist

E. Is sponsor (named in II. A., above) a DSHS approved instructor? (Circle one) YES / NO. If "NO", please complete and submit FORM F with the \$50.00 application fee by CERTIFIED CHECK OR MONEY ORDER payable to the Texas Department of State Health Services. This fee is non-refundable.

**PART III. INFORMATION SPECIFIC TO INSTITUTIONAL PROGRAMS**

A. Name of Institution: \_\_\_\_\_

B. Address (include city, state, zip code): \_\_\_\_\_  
\_\_\_\_\_

C. Business Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ extension \_\_\_\_\_

D. Name of Chief Executive Officer: \_\_\_\_\_  
Title: \_\_\_\_\_

E. List Agencies which accredit the institution: \_\_\_\_\_  
\_\_\_\_\_

F. Program Director's Name: \_\_\_\_\_

Program Director's Qualifications:

Check One: \_\_\_\_\_ Medical Radiologic Technologist                      \_\_\_\_\_ Physician

\_\_\_\_\_ Chiropractor                      \_\_\_\_\_ Podiatrist

Submit documentation, which demonstrates that the person has not less than three (3) years of experience teaching or instructing. Experience teaching in a limited medical radiologic technology program, which is not approved by the Texas Department of State Health Services, will not be considered as qualifying experience.

G. Is program director a Texas Department of State Health Services approved instructor? (Circle one) YES / NO  
If "NO", complete and submit FORM F.

H. Medical Advisor's Name and Texas License Number: \_\_\_\_\_  
\_\_\_\_\_

Check one: \_\_\_\_\_ Physician                      \_\_\_\_\_ Chiropractor                      \_\_\_\_\_ Podiatrist

**PART IV. OTHER INFORMATION**

A. List below any other person(s) responsible for the conduct of this program (Instructors or Faculty). Include what courses each person will teach/instruct or what areas they are responsible for (student admissions, student records, etc.). Attach an additional page if necessary.

1. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Course(s) to be taught or area of responsibility: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Years of teaching experience (if an instructor): \_\_\_\_\_

Credentials (if an instructor): \_\_\_\_\_

2. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Course(s) to be taught or area of responsibility: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Years of teaching experience (if an instructor): \_\_\_\_\_

Credentials (if an instructor): \_\_\_\_\_

3. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Course(s) to be taught or area of responsibility: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Years of teaching experience (if an instructor): \_\_\_\_\_

Credentials (if an instructor): \_\_\_\_\_

4. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Course(s) to be taught or area of responsibility: \_\_\_\_\_

\_\_\_\_\_

Years of teaching experience (if an instructor): \_\_\_\_\_

Credentials (if an instructor): \_\_\_\_\_

B. On a separate sheet of paper list each instructor's name, education, and experiences which uniquely qualify each person to train and instruct. Resumes, curriculum vitae (C.V.) and copies of licenses/certifications may be attached. Letters from employers should be submitted showing dates of employment, job duties, and job titles supporting the information you provided above or on C.V. or resume.

C. Professional conduct of Program Director or Independent Sponsor: (ALL QUESTIONS MUST BE ANSWERED. If explanations are necessary, use an additional page).

1. Have you ever had any diploma, credential, license, or certificate denied, revoked, or suspended?  
 YES                       NO                      If YES, explain fully.
2. Have you ever been found guilty of, pleaded guilty to, or entered a plea of “nolo contendere” to a charge of immoral conduct?  
 YES                       NO                      If YES, explain fully.
3. Have you ever been dismissed or asked to resign from any position for immoral or unprofessional conduct?  
 YES                       NO                      If YES, explain fully.
4. Have you ever been convicted of a felony or of a misdemeanor other than minor traffic offenses?  
 YES                       NO                      If YES, explain fully. NOTE: Driving while intoxicated (DWI) is NOT a minor traffic violation. If you received deferred adjudication for any crime it does not constitute a conviction.
5. Certification: I certify that the foregoing statements are true and correct.

\_\_\_\_\_ (Signature of Program Director or Independent Sponsor)

\_\_\_\_\_ (Date)

### **PART V. AGREEMENTS**

In accordance with the rules adopted by the Texas Board of Health, 25 TAC §143.9, the applicant program agrees to comply with the requirements for limited certificate programs which include but are not limited to the following items. Program director or independent sponsor must acknowledge agreement to comply by initialing in the space provided to the left of each item.

- \_\_\_\_\_ A. To teach and instruct the curriculum as submitted to and approved by the DSHS.
- \_\_\_\_\_ B. To provide educational and training opportunities for the students rather than primarily provide service to the independent sponsor in institutional sponsor, clinical facilities and their clients/patients.
- \_\_\_\_\_ C. To abide by admissions policies and graduation requirements which accompany this application and which have been provided to all students upon enrollment, including refund policies and conditions for dismissal and re-entrance.
- \_\_\_\_\_ D. To provide clinical supervision in a ratio of not more than three (3) students to one (1) full-time certified medical radiologic technologist.
- \_\_\_\_\_ E. To provide instruction or direction by a licensed practitioner while students are performing radiologic procedures on human beings and to prohibit students from performing radiologic procedures while not under the instruction or direction of a licensed practitioner.
- \_\_\_\_\_ F. To utilize equipment/devices which are licensed or registered with the DSHS – Bureau of Radiation Control.
- \_\_\_\_\_ G. To take measures necessary to prohibit unnecessary or excessive radiation to students, patients, instructors and faculty, and the public.
- \_\_\_\_\_ H. To utilize only medical facilities which are listed on PART I, item I., unless other facilities are approved in advance by DSHS for use in the limited certificate program.
- \_\_\_\_\_ I. To require all students to complete the required number of hours for classroom instruction, clinical instruction, and clinical experience in accordance with 25 TAC §143.9. The 100 hours of clinical instruction and shall be completed within 180 calendar days.
- \_\_\_\_\_ J. To maintain a record of each student’s attendance, evaluation instruments, grades, clinical experience and subjects completed for no less than five (5) years from the last date of the student’s attendance, and make records available to DSHS upon request.
- \_\_\_\_\_ K. To maintain records of students’ and instructors’ radiation exposure history in accordance with the Bureau of Control of Radiation Administrative Rules, 25 Texas Administrative Code §289.231 (m) and (n).

- \_\_\_\_\_ L. To not allow students to perform procedures using contrast media, fluoroscopy, computerized tomography, mammography,

nuclear medicine or radiation therapy.

\_\_\_\_\_ M. To issue to each student, upon successful completion of the program, a written statement/diploma/certificate which includes the program name, student's names, date of completion and signature of the medical advisor and independent sponsor or program director.

\_\_\_\_\_ N. To permit site inspections by DSHS representative in accordance with 25 TAC §143.9.

\_\_\_\_\_ O. To surrender to DSHS, the program approval and cease representing the program as approved if requested or instructed by DSHS, if the graduates' success rate(s) on the appropriate examination(s) is unsatisfactory, as determined by DSHS, or any other reason determined by DSHS as grounds for revocation of program approval.

\_\_\_\_\_ P. To cooperate with representative of the DSHS, Texas Education Agency or any other city, state or federal agency which are investigating complaints concerning the limited curriculum or the program.

\_\_\_\_\_ Q. To obtain a written determination from the Texas Education Agency as to whether the program or school where the limited curriculum will be taught must comply with the Texas Proprietary School Act.

**PART IV. ATTESTATION (MUST be signed while in the presence of a Notary Public)**

I certify that the information provided on this application is true and correct. I have read, understand and agree to abide by the Medical Radiologic Technologist Certification Act and the rules adopted by the Texas Department of State Health Services, including items a-q in Part V above.

I understand that providing false information of any kind may result in the voiding of this application, failure to be granted approval, or revocation of program approval. I understand that the \$450.00 application fee submitted is non-refundable. I also understand that a site visit is necessary and agree to pay the non-refundable site visit fee by MONEY ORDER or CERTIFIED CHECK whether or not program approval is granted.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Independent Sponsor or Program Director

The State of \_\_\_\_\_)

County of \_\_\_\_\_)

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_ known to me to be their person whose name is subscribed to the foregoing instrument, and having been by me duly sworn on oath, acknowledged that he/she had executed the same for the purposes and considerations therein expressed and that the foregoing statements are true and correct.

Given under my hand and seal of office, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Notary Public in and for the State of Texas or \_\_\_\_\_

\_\_\_\_\_ Signature of Notary

Seal or Stamp

\_\_\_\_\_ Printed Name of Notary

\_\_\_\_\_ Month, day, year



Budget # ZZ124  
Fund #124  
Fee: \$50.00

**FORM F**

**(f) Instructor approval for limited certificate programs.**

(1) All persons who plan to or who will provide instruction and training in the limited certificate courses of study or programs shall:

- (A) submit a completed application form prescribed by the department;
- (B) submit the prescribed application fee in accordance with §143.4 of this title;
- (C) document the appropriate instructor qualifications in accordance with subsection (g) of this

section.

(2) Guest lecturers who are not full or part-time employees of the sponsoring institution are not required to apply for instructor approval.

**(g) Instructor qualifications for limited certificate programs.**

(1) An instructor(s) shall have education and not less than six months classroom or clinical experience teaching the subjects assigned, shall meet the standards required by a sponsoring institution, if any, and shall meet at least one or more of the following qualifications:

- (A) be a currently certified MRT who is also currently credentialed as a radiographer by the American Registry of Radiologic Technologists (ARRT);
- (B) be a currently certified LMRT (excluding a temporary certificate) whose limited certificate category(ies) matches the category(ies) of instruction and training; or
- (C) be a practitioner who is in good standing with all appropriate regulatory agencies including, but not limited to, the department, the Texas State Board of Chiropractic Examiners, Texas State Board of Medical Examiners, or Texas State Board of Podiatry Examiners, the Texas Department of Human Services, and the United States Department of Health and Human Services.

(2) A limited medical radiologic technologist may not teach, train, or provide clinical instruction in a program or course of study different from the technologist's current level of certification. An LMRT who holds a limited certificate in spine radiography may not teach, train, or provide clinical instruction in a limited course of study for chest radiography.

Please attach certificate verifying licensure for MRT, LMRT(certificate showing what categories) and PRACTITIONER.

\_\_\_\_\_  
Instructor Name

\_\_\_\_\_  
Instructor License Type and License Number

\_\_\_\_\_  
Instructor Name

\_\_\_\_\_  
Instructor License Type and License Number

\_\_\_\_\_  
Instructor Name

\_\_\_\_\_  
Instructor License Type and License Number

\_\_\_\_\_  
Date