TEXAS MEDICAL RADIOLOGIC 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

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