

GENERAL INFORMATION AND APPLICATION INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS COMPLETELY BEFORE MAILING THE APPLICATION.

Any missing documents will slow the processing of your application.

Any reference to “licensure” in this application also means “certification” and “registration.”

1) Requirements for application:

To be eligible for certification, you must have **completed** an approved radiologic technology or radiologist assistant educational program or its equivalent in the field for which you are applying. Such program must be recognized and accepted by the American Registry of Radiologic Technologists (ARRT - www.arrt.org) or the Nuclear Medicine Technology Certification Board (NMTCB - www.nmtcb.org)

If you are **currently licensed** by a state or national organization (registry - ARRT or NMTCB) in the field for which you are applying, then you need to check “**by-endorsement**” on the application form, pay the certification by endorsement fee, and include a current copy of your license (wallet card or certificate) which shows your expiration date and type of licensure.

If you are **not currently registered**, then you need to check “**by-examination**” and pay the certification by examination fee (except for Radiologist Assistants, who are prohibited by Chapter 468, Part IV, Florida Statute, from applying by examination). This classification also must be used for those graduates of an approved program who are awaiting a national examination. We cannot grant certification until you have passed the State of Florida examination or one of the national registries as noted above, with a scaled score of 75.

2) **All applicants must submit:**

a. Proof of education. Submit proof of completion of the highest level of training in this field you have completed (college, university, hospital-based program, etc)

b. Verification of licensure from each state or organization where you have been disciplined or denied licensure. It is your responsibility to send the **License Verification Form, DH 4128**, to each state or organization.

3) **ALL FORMS** are available for download at: http://www.doh.state.fl.us/mqa/Rad-Tech/rad_forms.html

4) **HIV/AIDS AFFIDAVIT**- Florida law requires all applicants to complete an approved 4-hour HIV/AIDS education course that contains instruction on Florida’s HIV/AIDS laws. You must submit proof of completion in accordance with s. 381.0034, F.S. Courses can be located at <http://srdappsdo.h.doh.state.fl.us/RadTech/CeProviders.aspx>.

5) **APPLICANTS WHO WERE EDUCATED OUTSIDE OF THE UNITED STATES:** If an applicant cannot meet the requirements for graduation from an approved educational or training program solely because their radiologic technology education was received in a country other than the United States (U.S.), beyond the reach of U.S. accreditation mechanisms, the applicant may instead submit evidence that the radiologic technology education they received in the other country was substantially equivalent to the approved educational or training program required by the department. The department will determine, based on this evidence, whether the applicant’s education is substantially equivalent. All documents not in English must be translated by an official translator. Such evidence must include:

- a. **A license or registration in the applicant’s name to practice radiologic technology in the other country;**
- b. **An official transcript of the applicant’s radiologic technology education in the other country, showing all courses successfully completed, the grade received, the applicant’s full name, the graduation date, and the degree awarded; and**
- c. **A comprehensive, course-by-course evaluation of the U.S. equivalency of the applicant’s radiologic technology education by an international credential evaluation service which is a member of the National Association of Credentials Evaluations Services, at WWW.NACES.ORG.**

6) **DISCIPLINE OR DENIAL OF ANY HEALTH CARE LICENSE/CERTIFICATE OR BY ANY ORGANIZATION:**

Disciplinary action includes revocation, suspension, probation, reprimand, or being otherwise acted against, including being denied certification or resigning from or non-renewal of membership taken in lieu of or in settlement of a pending disciplinary denied certification or resigning from or non-renewal of membership taken in lieu of or in settlement of a pending disciplinary case.

7) **CRIMINAL BACKGROUND:** If you answered **YES** to the criminal history question (#7), you must submit the listed documentation and

- **Background History Report Form, DH 4127** for EACH incident.
- Law enforcement background check from each state where a misdemeanor or felony occurred. (For offenses committed in Florida, contact the Florida Department of Law Enforcement: www.fdle.state.fl.us)

- Letter of eligibility from the ARRT (if you applied for certification with the ARRT)
 - Copies of arrest report(s), court documents showing sentence, proof of completing all terms of sentence, including rehabilitation/treatment programs, proof of restoration of civil rights if such rights were removed due to felony conviction.
 - Reference letters and any other information/documents you would like taken into consideration.
- 8) Certificates expire the last day of your birth month, every other year. *Initial certificates will be issued for no less than 12 nor more than 24 months.* s. 468.307(1), F.S.
- 9) **ADA REQUESTS:** Please contact the ARRT at 651-687-0048
- 10) When this application is available online, education, HIV/AIDS course certificate, licensure verifications, criminal history information and specifically requested documents will need to be mailed to the department.
- 11) Examination fees are payable directly to the ARRT at www.ARRT.org. You will not be eligible to apply and pay until you are approved by the Florida Certification Office. You will receive an eligibility letter.
- 12) Your examination scores will not be mailed to you. They will be available approximately 14 days after you sit for the exam at: <http://www.doh.state.fl.us/mqa/Exam/home.htm>

BEFORE YOU MAIL YOUR APPLICATION...

- Have all questions on the application been answered or marked N/A?
- Is your application filled out in ink, signed and dated?
- Have you enclosed your 4 hour HIV/Aids course documents?
- Have you enclosed a money order or cashier check for the application fee?
- If you answered Yes to the criminal history or discipline questions, have you enclosed the required documents?

Contact Information:

MQA Call Center: 850-488-0595

General Information.

EMT/Paramedic/Rad Tech Certification Office:

Website: <http://www.doh.state.fl.us/mqa/Rad-Tech/>

E-mail: MQA_Rad-Tech@doh.state.fl.us

All Forms: http://www.doh.state.fl.us/mqa/Rad-Tech/rad_forms.html

License Verification/ Address Change/Renewal: www.flhealthsource.com

Exam Results: <http://www.doh.state.fl.us/mqa/Exam/home.htm>

Mailing address for application and fees:

Florida Department of Health
EMT/PMD/Rad Tech Certification Office
PO Box 6330
Tallahassee, FL 32314-6330

Mailing address for any correspondence containing no fees:

Florida Department of Health
EMT/PMD/Rad Tech Certification Office
4052 Bald Cypress Way BIN C85
Tallahassee, FL 32399-3285

The practice of Basic X-Ray Machine Operator, Radiologic Technology and Radiologist Assistant are regulated under Chapter 468, Part IV, Florida Statutes and Section 64E-3, Florida Administrative Code. Both are available for viewing or download on our website. <http://www.doh.state.fl.us/mqa/Rad-Tech/>



**Application for General Radiographer,
Nuclear Medicine Technologist,
Radiation Therapy Technologist or
Radiologist Assistant**

Please TYPE or PRINT in CAPITAL LETTERS in ink. Please read instructions carefully before completing. All sections of this application are required to be completed unless otherwise noted. Omissions will delay processing.

Pursuant to Chapter 468, Part IV, Florida Statutes, no person shall use radiation on a human being or otherwise practice radiologic technology unless he or she is certified or licensed by the State of Florida as a radiologic technologist, radiologist assistant, basic x-ray machine operator, physician, podiatrist, chiropractor, or naturopath.

1. APPLICANT INFORMATION

_____/_____/_____
 Last Name First Name Middle Initial Date of Birth

 Mailing Address for correspondence City State Zip Code

If your mailing address is a PO Box, provide your street address as well.

Day time phone # (____) _____ Home phone # (____) _____ Email _____

2. PERSONAL INFORMATION: This section is optional.
 Gender: Male Female
 Ethnicity: White Native American Asian/Pacific Islander Black Hispanic Other _____

3. Would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster if you employer releases you to do so? Yes No

4. APPLICATION TYPE: Indicate below the type of certificate you seek and the method you wish to use to qualify for certification in Florida. Limit one method per application. Radiologist Assistant is by endorsement only.

TYPE OF CERTIFICATE	METHOD OF QUALIFICATION		
<input type="checkbox"/> General Radiographer (GR) (7601)	<input type="checkbox"/> Exam \$50.00 (1043)	<input type="checkbox"/> Re-exam \$35.00 (1051)	<input type="checkbox"/> Endorsement \$45.00 (1031)
<input type="checkbox"/> Nuclear Medicine Technologist (NMT) (7601)	<input type="checkbox"/> Exam \$50.00 (1042)	<input type="checkbox"/> Re-exam \$35.00 (1053)	<input type="checkbox"/> Endorsement \$45.00 (1031)
<input type="checkbox"/> Radiation Therapy Technologist (RTT) (7601)	<input type="checkbox"/> Exam \$50.00 (1041)	<input type="checkbox"/> Re-exam \$35.00 (1052)	<input type="checkbox"/> Endorsement \$45.00 (1031)
<input type="checkbox"/> Radiologist Assistant (RA) (7602)	N/A	N/A	<input type="checkbox"/> Endorsement \$45.00 (1031)

5. PROFESSIONAL EDUCATION (submit a copy of your graduation certificate/diploma)

Indicate the type of program you completed: General Radiographer Nuclear Medicine Technologist
 Radiation Therapy Technologist Radiologist Assistant
 Other _____

Name, city and state of Program: _____

Type of diploma: Degree Certificate Graduation Date: _____

Type of teaching facility: College/University Junior/Community College Hospital
 Military On-the-Job Training Other _____

6. LICENSURE/ CERTIFICATION/ REGISTRATION (The term "licensure" as used here also means "certification" and "registration").

a. Have you ever been licensed by any state or national organization (registry) in Radiologic Technology or in any other health care field? Yes No

If YES complete the table below for all such licenses and attach a copy of your current license or wallet card which shows your expiration date.

b. Have you ever been denied licensure or had disciplinary action* taken against you or your health care license?

Yes No (*Disciplinary action includes revocation, suspension, probation, reprimand, or being otherwise acted against, including being denied certification or resigning from or non-renewal of membership taken in lieu of or in settlement of a pending disciplinary case)

If YES, attach a written explanation for each action and have each state or organization which denied you or took action against you fill out a *License Verification Form* (DH 4128) and send directly to our office.

State or Organization	Type of License				License Number	Expiration Date	Disciplinary Action
	Radiographer	Nuclear Medicine Technologist	Radiation Therapy Technologist	Other (Specify)			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No

7. CRIMINAL BACKGROUND

Have you ever been convicted of, pled nolo contendere (no contest) to, or had adjudication of guilt withheld for any violation of any state or federal law in any jurisdiction? Yes No

If YES, complete a *Background History Form* (DH 4127) for each offense and follow the instructions for submitting complete information about your criminal background, including a law enforcement background check.

8. HIV/AIDS COURSE

Have you completed the Florida-approved 4-hour HIV/AIDS course required under s. 381.0034, Florida Statutes? Yes No

If YES, please enclose a copy of the course certificate. (If NO, please see instructions for information on where to obtain this course.)

9. OATH: (Must Be Completed)

I, the undersigned, state that I am the person referred to in this application for certification in the State of Florida. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind and I declare under penalty of perjury that my answers and all statements made by me herein and attached are true and correct. Should I furnish any false information in this application I hereby agree that such act shall constitute cause for denial, suspension or revocation of my certificate to practice as a Application for General Radiographer, Nuclear Medicine Technologist, Radiation Therapy Technologist or Radiologist Assistant in the State of Florida.

I hereby agree to abide by all the rules and regulations of the State of Florida and to permit the State or its duly authorized representative, at all reasonable times, opportunity to inspect my certificate.

I understand that Florida law requires me to immediately inform the certification office of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the certificate and to supplement the information on this application as needed.

Applicant signature _____ Date _____



LICENSE VERIFICATION FORM

EMT/PARAMEDIC/RADIOLOGIC TECHNOLOGY OFFICE
4052 BALD CYPRESS WAY, BIN C85 - TALLAHASSEE, FL 32399-3285
(850) 245-4910 - (850) 921-6365 FAX

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE APPLICANT WHO ANSWERS "YES" TO QUESTION 6b. ON PAGE 2 OF THE RADIOLOGIC TECHNOLOGY APPLICATION (DH 1005/1006). AFTER COMPLETION, THE APPLICANT IS TO MAIL THIS FORM TO EACH ORGANIZATION WHERE HE/SHE HOLDS OR HAS HELD A LICENSE, REGISTRATION OR CERTIFICATE TO PRACTICE RADIOLOGIC TECHNOLOGY OR OTHER HEALTH PROFESSION.

I, _____ HOLDING LICENSE/CERTIFICATE/REGISTRATION NUMBER _____, ISSUED BY
APPLICANT'S FULL NAME (PRINT) _____ NUMBER _____
_____, HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE ALL INFORMATION CONCERNING ME,
VERIFYING ORGANIZATION _____,
FAVORABLE OR OTHERWISE, DIRECTLY TO THE FLORIDA DEPARTMENT OF HEALTH, RADIOLOGIC TECHNOLOGY PROGRAM.

APPLICANT'S SIGNATURE

DATE

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE VERIFYING ORGANIZATION, WHICH SHOULD MAIL THIS VERIFICATION DIRECTLY TO THE DEPARTMENT ADDRESS ABOVE. PLEASE USE AN ADDITIONAL SHEET IF NEEDED FOR ANY RESPONSE. QUESTIONS SHOULD BE DIRECTED TO DEPARTMENT PERSONNEL AT THE PHONE NUMBER LISTED ABOVE.

LICENSE/CERTIFICATE/REGISTRATION NUMBER _____ WAS ISSUED ON _____ AND EXPIRES ON _____.

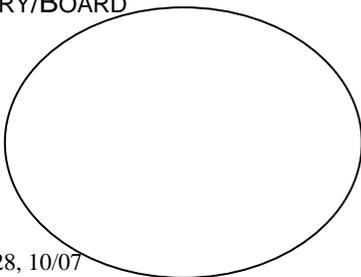
IS THIS LICENSE/CERTIFICATE/REGISTRATION CURRENT? ___ YES ___ NO IF NO, PLEASE EXPLAIN.

HAS YOUR ORGANIZATION EVER REVOKED, SUSPENDED, SURRENDERED, RESTRICTED, PLACED ON PROBATIONARY STATUS OR PUT UNDER INVESTIGATION THIS LICENSE/CERTIFICATE/REGISTRATION? ___ YES ___ NO IF YES, PLEASE EXPLAIN.

HAS YOUR ORGANIZATION EVER BROUGHT ANY DISCIPLINARY CHARGES AGAINST THIS PERSON? ___ YES ___ NO IF YES, PLEASE EXPLAIN.

DOES YOUR ORGANIZATION PRESENTLY HAVE ANY LEGAL ACTION/COMPLAINTS PENDING AGAINST THIS PERSON? ___ YES ___ NO IF YES, PLEASE EXPLAIN.

NOTARY/BOARD
SEAL



NAME (PLEASE PRINT)

SIGNATURE

VERIFYING ORGANIZATION

DATE



BACKGROUND HISTORY REPORT FORM

EMT/PARAMEDIC/RADIOLOGIC TECHNOLOGY OFFICE
4052 BALD CYPRESS WAY, BIN C85 - TALLAHASSEE, FL 32399-3285
(850) 245-4910 - (850) 921-6365 FAX

INSTRUCTIONS: PLEASE COMPLETE THIS FORM FOR ALL INCIDENTS FOR WHICH YOU WERE CONVICTED, OR ENTERED A PLEA OF NOLO CONTENDERE, OR HAD ADJUDICATION OF GUILT WITHHELD. USE A SEPARATE FORM FOR EACH INCIDENT AND DO NOT LEAVE ANY SECTIONS BLANK. ATTACH COPIES OF ALL DOCUMENTS REQUESTED BELOW. NOTE: YOUR APPLICATION IS INCOMPLETE WITHOUT THIS INFORMATION.

1. APPLICANT NAME: _____	DATE OF BIRTH: _____
2. NAME & ADDRESS OF ARRESTING AGENCY: (ATTACH POLICE ARREST REPORT) _____	CASE #: _____
	DATE ARRESTED: _____
3. CHARGE(S): (LIST ALL CHARGES CONNECTED WITH ARREST & INDICATE WHETHER FELONY OR MISDEMEANOR): _____ _____ _____	
4. NAME, ADDRESS & PHONE NUMBER OF COURT WHERE SENTENCED: _____	CASE #: _____
	DATE SENTENCED: _____
5. DISPOSITION OF CHARGE(S): (INDICATE DISPOSITION OF EACH CHARGE AT TIME OF SENTENCING)	
<input type="checkbox"/> NOT GUILTY _____	<input type="checkbox"/> GUILTY _____
<input type="checkbox"/> ADJ. WITHHELD _____	<input type="checkbox"/> NOLLE PROSSED _____
<input type="checkbox"/> OTHER (SPECIFY) _____	
6. TERMS OF SENTENCE: (LIST DETAILS OF EACH TERM BELOW & ATTACH COURT DOCUMENTS)	
<input type="checkbox"/> INCARCERATION _____	<input type="checkbox"/> PROBATION _____
<input type="checkbox"/> RESTITUTION _____	<input type="checkbox"/> REHAB/TREATMENT _____
<input type="checkbox"/> FINE _____	<input type="checkbox"/> HOUSE ARREST _____
<input type="checkbox"/> COMMUNITY SERVICE _____	<input type="checkbox"/> OTHER (SPECIFY) _____
7. HAVE ALL TERMS OF SENTENCE BEEN COMPLETED? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF "YES", ATTACH PROOF; IF "NO" EXPLAIN)	
_____ _____ _____	
8. IF CONVICTED OF A FELONY, HAVE YOUR CIVIL RIGHTS BEEN RESTORED? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, ATTACH PROOF)	

