GENERAL INFORMATION AND APPLICATION INSTRUCTIONS

- **General Radiographer**
- **Nuclear Medicine Technologist**
- **Radiation Therapy Technologist**
- **Computed Tomography**
- **Mammography**
- **Magnetic Resonance Imaging**
- **Radiologist Assistant**

Please read these instructions completely before completing and mailing the application. Any missing documents will delay the processing of your application. Any reference to "licensure" in the application also means "certification" and "registration."

1) REQUIREMENTS FOR APPLICATION:

To be eligible for certification, you must have successfully completed an approved educational/training program in the same area of radiologic technology for which you are applying for certification. Such programs must be recognized and accepted by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) – (contact information for all approved programs, including the accredited school/college name, address and program director's name, is found on the registry websites at www.arrt.org and www.nmtcb.org).

If you are currently licensed by a national organization (a registry – ARRT, NMTCB, or a state which uses these registry examinations) 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 (or wallet card) which shows your expiration date, name, and type of licensure.

If you are not currently licensed, then you need to check **"by-examination"** and pay the certification by examination fee (however, as noted in section 4 of the application, not all license types are available for licensure by examination under state law). This application type should also be used for those graduates of an approved program who are currently scheduled for a national examination.

Regardless of whether you apply by exam or by endorsement, we cannot grant certification until you have passed the State of Florida examination, or one of the national registry exams 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, Florida Statutes. Courses can be located at http://srdappsdoh.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 accompanied by a certified translation in English. 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 answer **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 or no more than 24 months**, s. 468.307(1), Florida Statutes.

9) ADA REQUESTS: Please contact the ARRT at 651-687-0048.

10) 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 and have received an eligibility letter.

11) 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.

12) An incomplete application expires six (6) months after initial filing with the department, s. 468.304(2), Florida Statutes.

BEFORE YOU MAIL YOUR APPLICATION:

- ☐ Have all questions on the application been answered or marked N/A?
- ☐ Is your application typed or filled out in ink, signed and dated?
- ☐ Have you enclosed all requested educational and licensure documents?
- ☐ Have you enclosed your 4-hour HIV/AIDS course documents?
- ☐ Have you enclosed a money order or cashier's 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 - General Information: **850-488-0595**

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 the Application Fees:
Florida Department of Health
EMT/PMD/Rad Tech Certification Office
P.O. Box 6330
Tallahassee, Florida 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 C-85
Tallahassee, Florida 32399-3285

The practice of each profession listed on this application is regulated under Chapter 468, Part IV, Florida Statutes, and Chapter 64E-3, Florida Administrative Code. Both of the documents are available for viewing or download on our website at http://www.doh.state.fl.us/mqa/Rad-Tech/.

APPLICATION FOR:

- **General Radiographer**
- **Nuclear Medicine Technologist**
- **Radiation Therapy Technologist**
- **Computed Tomography**
- **Mammography**
- **Magnetic Resonance Imaging**
- **Radiologist Assistant**

Please **TYPE** or **PRINT** in ink in **CAPITAL LETTERS**. 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 P.O. Box, provide your street address as well.

Daytime 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 your 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. Please note as indicated below some certificates are available by endorsement method only.

TYPE OF CERTIFICATE	METHOD OF QUALIFICATION		
☐ **General Radiographer (GR) (7601)**	☐ **Exam $50.00 (1043)**	☐ **Re-exam $35.00 (1051)**	☐ **Endorsement $45.00 (1031)**
☐ **Nuclear Medicine Technologist (NMT) (7601)**	☐ **Exam $50.00 (1042)**	☐ **Re-exam $35.00 (1052)**	☐ **Endorsement $45.00 (1031)**
☐ **Radiation Therapy Technologist (RTT) (7601)**	☐ **Exam $50.00 (1041)**	☐ **Re-exam $35.00 (1053)**	☐ **Endorsement $45.00 (1031)**
☐ **Computed Tomography (CT) (7601)**	**N/A**	**N/A**	☐ **Endorsement $45.00 (1031)**
☐ **Mammography (M) (7601)**	**N/A**	**N/A**	☐ **Endorsement $45.00 (1031)**
☐ **Magnetic Resonance Imaging (MR) (7601)**	**N/A**	**N/A**	☐ **Endorsement $45.00 (1031)**
☐ **Radiologist Assistant (RA) (7602)**	**N/A**	**N/A**	☐ **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**
☐ **Computed Tomography**
☐ **Other** ________________________________
☐ **Mammography**
☐ **Magnetic Resonance Imaging**
☐ **Radiologist Assistant**

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.

	Type of License								License Number	Expiration Date	Disciplinary Action*
State or Organization	Radiographer	Nuclear Medicine Technologist	Radiation Therapy Technologist	Computed Tomography	Mammography	Magnetic Resonance Imaging	Radiologist Assistant	Other (Specify)			
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No
	☐	☐	☐	☐	☐	☐	☐				☐ Yes ☐ No

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 other wise 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.

CRIMINAL BACKGROUND:

7. **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**, please 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 any certificate issued to me pursuant to this application.

   I understand that the practice of my profession is governed by Chapter 468, Part IV, Florida Statutes, and Chapter 64E-3, Florida Administrative Code, both of which are available at: http://www.doh.state.fl.us/mqa/Rad-Tech.

   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 as needed.

Applicant's signature:_____ **Date:**_____

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

- **General Radiographer**
- **Nuclear Medicine Technologist**
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*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA s. 666(a)(13). For all professions regulated under Chapter 468, Part IV, Florida Statutes, the collection of Social Security Numbers is required by section 468.304(2), Florida Statutes.

Name:_____
Last **First** **Middle**

Social Security Number: _____

Applicant's Signature: _____ **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 & FDLE ARREST REPORT) **CASE #:** _____

DATE ARRESTED: _____

3: CHARGE(S): **(LIST ALL CHARGES CONNECTED WITH ARREST & INDCATE 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)**

☐ **NOT GUILTY** _____ ☐ **GUILTY** _____

☐ **ADJ. WITHHELD** _____ ☐ **NOLLE PROSSED** _____

☐ **OTHER (SPECIFY)**

6. TERMS OF SENTENCE: (LIST DETAILS OF EACH TERM BELOW & ATTACH COURT DOCUMENTS)

☐ **INCARCERATION** _____ ☐ **PROBATION** _____

☐ **RESTITUTION** _____ ☐ **REHAB/TREATMENT** _____

☐ **FINE** _____ ☐ **HOUSE ARREST** _____

☐ **COMMUNITY SERVICE** _____ ☐ **OTHER** (SPECIFY) _____

7. HAVE ALL TERMS OF SENTENCE BEEN COMPLETED? ☐ **YES** ☐ **NO (IF "YES", ATTACH PROOF; IF "NO" EXPLAIN)**

_____

_____

_____

8. IF CONVICTED OF A FELONY, HAVE YOUR CIVIL RIGHTS BEEN RESTORED? ☐**YES** ☐ **NO** **(IF YES, ATTACH PROOF)**

9. DESCRIPTION OF EVENTS: (P) ROVIDE YOUR WRITTEN EXPLANATION OF EVENTS LEADING TO ARREST

I DECLARE, SUBJECT TO THE PENALTIES FOR PERJURY, THAT ALL THE INFORMATION ON THIS FORM, OR ATTACHED THERETO, IS ACCURATE AND TRUE. I FURTHER UNDERSTAND THAT A FALSE STATEMENT MADE BY ME MAY BE CAUSE FOR CRIMINAL PROSECUTION AND PUNISHMENT, OR FOR DENIAL, REVOCATION, SUSPENSION, OR RESTRICTION OF ANY CERTIFICATE ISSUED PURSUANT TO THIS FORM.

SIGNATURE:_____ **DATE:** _____/___ /_____

LICENSE VERIFICATION FORM

EMT/PARAMEDIC/RADIOLOGIC TECHNOLOGY OFFICE
4052 BALD CYPRESS WAY, BIN C85 ·TALLAHASSEE, FL 32399-
(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

_____
DATE