GENERAL INFORMATION AND INSTRUCTIONS FOR APPLICATION FOR

- **Basic X-Ray Machine Operator or**
- **Basic X-Ray Machine Operator – Podiatric Medicine**

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. This application form (DH 1006, 07/16) may be used to apply for certification for Basic X-Ray Machine Operator or Basic X-Ray Machine Operator-Podiatric Medicine. Please return all three (3) pages of the application along with your money order or cashiers check made payable to the Bureau of Radiation Control for the total amount of your fees to the address below.

   All applicants must complete a review of the Limited Scope Radiographer study guide materials (available from *http://www.floridahealth.gov/environmental-health/radiation-control/radtech/study-guide.html*) or a substantially equivalent program as described in Florida Administrative Code, Rule 64E-3.003(1)(d). If you have not completed a review of the study materials, or a substantially equivalent program, DO NOT APPLY yet. Reviewing the materials takes many weeks or months, depending on your pace, and applying before you are ready to schedule the examination may result in the loss of your exam window and your non-refundable fee.

   If you are currently licensed as a limited-scope radiographer by a state licensing agency that used the ARRT's (American Registry of Radiologic Technologist's) limited-scope radiography exam for your state exam, then you need to check **by endorsement** and include a copy of your state license, you state exam scores (including section name and scores), and a letter from the agency indicating the exam used was the ARRT's exam. If you are not currently licensed as described above, then you need to check **by examination.**

2. **ALL APPLICANTS** must be 18 years of age and provide proof of high school graduation or completion of high school equivalency (GED). For proof of age, submit a copy of your valid Driver's License or other government-issued ID showing date of birth with your application.

3. **ALL FORMS** are available for download under the "Applications and Forms" link at: *http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology*.

4. **DISCIPLINE OR DENIAL OF ANY HEALTH CARE LICENSE, CERTIFICATE OR REGISTRATION**: You must report (see question #6b on the application form) any denial of licensure or disciplinary action taken against you or your health care license, registration or certification. 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 you answer "Yes" to question #6b,** you must attach a written explanation to your application and also send the ***License Verification Form***, DH 4128, to each state or organization that disciplined or denied you licensure, certification or registration.

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

6. **BACKGROUND HISTORY**: If you answered **YES** to the background 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 at: *http://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.

7. **CERTIFICATES EXPIRE** on 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), Florida Statutes.*

8. **AMERICANS WITH DISABILITIES ACT (ADA) REQUESTS**: Please contact the ARRT at (651) 687-0048, ext. 3155 for information about test accommodations requests.

9. **EXAMINATION FEES** are payable directly to the ARRT at: *https://www.staterhc.org/state/FL*. You will **not** be eligible to pay for your exam until you are approved by the Florida Certification Office and have received an eligibility letter with payment instructions.

10. **EXAMINATION SCORES** will not be mailed to you. They will be available under the "Examination Grade Report" link at, *http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology* approximately 14 days after you sit for the exam.

11. **THE PRACTICE** of Basic X-Ray Machine Operator and Basic X-Ray Machine Operator-Podiatric Medicine is regulated under Chapter 468, Part IV, Florida Statutes, and Florida Administrative Code, Chapter 64E-3. These documents, as well as the "Disciplinary Guidelines for Radiological Personnel," are available at: *http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology/resources*.

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 filled out in ink, signed and dated?
- ☐ Have you enclosed all requested educational and licensure documents?
- ☐ Have you enclosed a money order or cashier check for the application fee?
- ☐ If you answered YES to the background history or discipline questions, have you enclosed the required documents?

CONTACT INFORMATION:

MQA Call Center - General Information: (850) 488-0595

MQA Radiologic Technology Certification Office:

Website: **http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology**

E-mail: **mqa.rad-tech@flhealth.gov**

Forms: **http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology**
(Click on the "Applications and Forms" link.)

Address Change or Update Profile: http://www.flhealthsource.gov/mqa-services

License Verification: http://www.flhealthsource.gov

Exam Scores: **http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology**
(Click on the "Examination Grade Report" link.)

Mailing address for application and fees:

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

Mailing address for correspondence containing no fees:

Florida Department of Health
EMT/PMD/Rad Tech Certification Office
4052 Bald Cypress Way, BIN C-85
Tallahassee, FL 32399-3285

APPLICATION FOR CERTIFICATION AS A:

- **Basic X-Ray Machine Operator or**
- **Basic X-Ray Machine Operator – Podiatric Medicine**

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.

TYPE OF CERTIFICATE	METHOD OF QUALIFICATION		
☐ **Basic X-Ray Machine Operator (BMO) (7601)**	☐ **Exam $50.00 (1009)**	☐ **Re-exam $35.00 (1050)**	☐ **Endorsement $45.00 (1030)**
☐ **Basic X-Ray Machine Operator Podiatric Medicine (BMOP)(7601)**	☐ **Exam $50.00 (1018)**	☐ **Re-exam $35.00 (1054)**	☐ **Endorsement $45.00 (1030)**

5. EDUCATION – HIGH SCHOOL: (submit a copy of your diploma or GED certificate)

a. Did you graduate from high school? ☐ Yes ☐ No

If YES, your name at graduation _____**Year of graduation**_____

Name, city, state of high school_____

b. If NO, have you passed a high school equivalency test? (GED) ☐ Yes ☐ No

Equivalency certificate number_____ **Year of completion**_____

Your name when you passed the exam _____

City, state where you took the exam _____

EDUCATION – BASIC X-RAY MACHINE OPERATOR:

c. Have you completed your review of the Limited-Scope Radiographer study guide materials? ☐ Yes ☐ No

d. Have you completed a Basic X-Ray Machine Operator or Limited-Scope Radiographer educational program?
☐ Yes ☐ No

If you attended a program: When did you graduate? _____ (Please attach a copy of your certificate)
Name and address of program:_____

e. Have you completed a Medical Assisting program which had a Basic X-Ray Machine Operator component?
☐ Yes ☐ No

If you attended a program: When did you graduate? _____ (Please attach a copy of your certificate)
Name and address of program:_____

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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 that 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 to this application for each action and have <u>each</u> state or organization that 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
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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7. BACKGROUND HISTORY:

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. STATEMENT OF APPLICANT:

I, the undersigned:

Understand that furnishing false information in this application shall constitute cause for denial, suspension or revocation of any certificate issued to me pursuant to this application.

Understand that the practice of my profession is governed by Chapter 468, Part IV, Florida Statutes, and Florida Administrative Code, Chapter 64E-3, and the "Disciplinary Guidelines for Radiological Personnel," all of which are available at: *http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology/resources*.

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.

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 that takes place between the initial filing and the final granting or denial of the certificate and to supplement the information as needed.

OATH OR AFFIRMATION (Must Be Completed):

I, the undersigned, do swear or affirm that I am the person referred to in this application for certification in the State of Florida, that I am at least 18 years of age, I am of good moral character and that I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and declare under penalty of perjury that the answers and all statements made by me herein and attached are true and correct.

STATE OF _____

COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20_____, by

_____ who is_____ personally known OR _____ produced identification.

Type of identification presented: _____

_____
Signature of Notary Public

_____
Print, Type or Stamp Commissioned Name of Notary

PURSUANT TO § 117.021, FLORIDA STATUTES, OATHS/AFFIRMATIONS CAN BE MADE ELECTRONICALLY.]

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

- **Basic X-Ray Machine Operator or**
- **Basic X-Ray Machine Operator-Podiatric Medicine**

*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 s. 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:** _____/___ /_____

DH 4127, 10/07

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

Department of Health
Military Veteran Fee Waiver Request

Submit all the items on the checklist below with your request for fee waiver.

Application Checklist

- ☐ Complete Licensure Application
- ☐ DD-214 or NGB-22
- ☐ Complete Waiver Request

Mail your complete application for licensure, waiver request, and any required fee(s) to:

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330

General Information:

To qualify for this waiver you must be:

- A military veteran who has been honorably discharged or who will be honorably discharged within six months of submitting your application or;
- The spouse of a military veteran who has been honorably discharged or who will be honorably discharged within six months of submitting your application.

Applicants approved for this waiver will have the initial licensure fee, initial application fee and unlicensed activity fee waived. The waiver may not waive all fees for an application. The fees that may be required to be paid will vary depending on the profession for which you are applying. The waiver does not waive examination fees.

Department of Health
Military Veteran or Spouse Fee Waiver Request

Personal Information:		
Last/Surname First Middle		
License Applying for:	Phone Number:	Email Address:
Mailing Address:		
City	State	ZIP Code

Complete this section if you are a Military Veteran:
1a. Were you honorably discharged from a branch of the United States Armed Forces or will you be honorably discharged within six months of submitting your application? ☐ Yes ☐ No
1b. What was your name at the time of discharge from the United States Armed Forces? _____
1c. Date of your honorable discharge from the United States Armed Forces: _____ MM/YYYY

Complete this section if you are the Spouse of a Military Veteran:
2a. Are you the spouse of a member of the United States Armed Forces who has been honorably discharged or will be honorably discharged within six months of submitting your application? ☐ Yes ☐ No
2b. What was the name of your spouse at the time of discharge? _____
2c. Date of your spouse's honorable discharge from the United States Armed Forces: _____ MM/YYYY

Applicant Signature:	
Signature:	Date: _____ MM/DD/YYYY