



GENERAL INFORMATION AND INSTRUCTIONS FOR APPLICATION FOR RADIOLOGIC TECHNOLOGY CERTIFICATION

- General Radiographer
- Nuclear Medicine Technologist
- Radiation Therapy Technologist
- Computed Tomography
- Positron Emission Tomography
- Mammography
- 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 <http://www.arrt.org> and <http://www.nmtcb.org>).

If you are currently licensed as a radiographer, nuclear medicine technologist, radiation therapy technologist or radiologist assistant by a national organization (the ARRT or NMTCB), or a state who uses the ARRT examinations, and you are applying for the same license type, then you may 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. You may also apply by endorsement for a specialty license type if you currently have the same license from one of the approved organizations and types listed in Florida Administrative Code (F.A.C.) Rule 64E-3.0034.

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. Proof of age. Submit a copy of your valid Driver’s License or other government-issued ID showing date of birth. You must be at least 18 to be certified.

3) ALL FORMS ARE AVAILABLE FOR DOWNLOAD AT:

<http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology/applications-forms/>.

4) 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: <http://www.naces.org>.

5) 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 #6**, 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.

6) BACKGROUND HISTORY:

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 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 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.**

8) AMERICANS WITH DISABILITIES ACT (ADA) REQUESTS: Please contact the ARRT at (651) 687-0048, ext. 3155 for information about test accommodation 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) 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 a money order or cashier's 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, Florida 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, Florida 32399-3285

The practice and disciplinary guidelines of each profession listed on this application is regulated under Chapter 468, Part IV, Florida Statutes, and Chapter 64E-3, F.A.C. These documents, as well as the "Disciplinary Guidelines for Radiological Personnel," are available at:
<http://www.floridahealth.gov/licensing-and-regulation/radiologic-technology/resources>.



APPLICATION FOR RADIOLOGIC TECHNOLOGY CERTIFICATION:

- General Radiographer
- Nuclear Medicine Technologist
- Radiation Therapy Technologist
- Computed Tomography
- Positron Emission Tomography
- Mammography
- 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		
<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 (1052)	<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 (1053)	<input type="checkbox"/> Endorsement \$45.00 (1031)
<input type="checkbox"/> Computed Tomography (CT) (7601)	N/A	N/A	<input type="checkbox"/> Endorsement \$45.00 (1031)
<input type="checkbox"/> Positron Emission Tomography (PET) (7601)	N/A	N/A	<input type="checkbox"/> Endorsement \$45.00 (1031)
<input type="checkbox"/> Mammography (M) (7601)	N/A	N/A	<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 Positron Emission Tomography
 Nuclear Medicine Technologist Mammography
 Radiation Therapy Technologist Radiologist Assistant
 Computed Tomography
 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.

State or Organization	Type of License								License Number	Expiration Date	Disciplinary Action*
	Radiographer	Nuclear Medicine Technologist	Radiation Therapy Technologist	Computed Tomography	Positron Emission Tomography	Mammography	Radiologist Assistant	Other (Specify)			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> 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 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 each 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.

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**, please complete a **Background History Form (DH 4127)** for each offense and follow the instructions for submitting complete information about your background history, 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, Chapter 64E-3, F.A.C., and the "Disciplinary Guidelines for Radiologic 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 which 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.]



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 & 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)	



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** _____

_____, **VERIFYING ORGANIZATION**, HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE ALL INFORMATION CONCERNING ME, 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