

\*\*\*FOR OFFICE USE ONLY\*\*\*

**Radiologic Tech Checklist**

- Endorsement       Examination
- Grad Status
- App. & Fee
- Date: \_\_\_\_\_ Check \_\_\_\_\_
- Photo
- Transcript or ARRT Education Cert.
- Exam Results from ARRT
- NMTCB Verification Form
- Lic. Verification from other States



\*\*\*FOR OFFICE USE ONLY\*\*\*

Application Approved:
License Number:
Issue Date:
Grad License Number:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

**Rhode Island  
Board of Radiologic Technology**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For  
License As A***

License # \_\_\_\_\_  
Name \_\_\_\_\_

- Radiographer
- Nuclear Medicine Technologist
- Radiation Therapist
- Supplemental CT
- Endorsement**       **Examination**
- Graduate Status     Yes       No

**MILITARY STATUS ELIGIBILITY**

*(Documentation Required)  
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

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*LAST NAME*

*FIRST NAME*

*MI*

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

# GENERAL INFORMATION

## Enclosures

The following materials and information should be enclosed within this application packet:

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## Licensure Requirements

- Non-Refundable application fees as follows:

<b>Nuclear Medicine Technologist</b>	<b>\$85.00</b>
<b>Radiation Therapist</b>	<b>\$85.00</b>
<b>Radiologist Assistant</b>	<b>\$85.00</b>
<b>Radiographer</b>	<b>\$60.00</b>
- Supplemental CT application fee **\$50.00**. (if applicable)
- Recent 2x2 photograph of yourself
- Official school transcript is required for applicants applying for licensure by “Examination”
- An endorsement applicant (someone already licensed in another state) shall request an original certification from the ARRT or NMTCB **verifying** that you are a graduate of an educational program approved by the ARRT or NMTCB. Such certification **must** be sent directly from the above agency to this office. If the certification is not sent to us by ARRT or NMTCB, we will require that proof of the educational program be sent **directly** to us from the program.
- Score/verification of completion of the national certification examination given by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB).

Note: For radiographers and radiation therapists applicants, if you choose this option, please note the certification from the ARRT must also include the score/verification of your national certification examination. For nuclear medicine technologists applicants, you **must** use the “Nuclear Medicine Technologist Verification of Certification” form on page (11) of this application.

## Endorsement Candidates

- Verification of licensure sent directly from other state(s) boards in which applicant holds or has held a license to the Rhode Island Department of Health.

## Military Expedited

If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

## **Rules and Regulations/Laws**

To obtain the Rules and Regulations for your profession visit the following web site. From the list click on your profession.

<http://www.health.ri.gov/licenses/>

Title 5, Chapter 68, entitled: Board of Radiologic Technology can be downloaded at the following web site:

<http://www.rilin.state.ri.us/statutes/title5/5-68/INDEX.HTM>

## **APPLICATION PROCESS OVERVIEW**

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The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), and the Rhode Island Board of Radiologic Technology.

### **Application Process**

In addition to the application, you must submit additional information directly to the Board. All items listed on the “checklist” (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 4-6 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

<http://www.health.ri.gov/forms/changeofaddress/professions.pdf>

***To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:***

<https://healthri.mylicense.com/Verification/>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-2828.

# INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION

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Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

## General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

## Completing your Application

1. Complete the application (pages 5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Complete the supplemental CT application on page (13) (if applicable)
3. Make check or money order (in U.S. funds only) for the application fee payable to **Rhode Island General Treasurer** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NON-REFUNDABLE.
4. Affix a recent **2 X 2 photo** of yourself in the space provided.
5. **Examination Applicants** A completed official transcript must be sent directly from the accredited school of **Radiologic Technology** to the address listed below. No student copies will be accepted.

**Endorsement Applicants** Please note that if ARRT or NMTCB verifies that you are a graduate of a program approved by the ARRT or NMTCB you are **not** required to submit transcripts. However, if ARRT or NMTCB does not verify your educational program, then the transcript must be sent directly from your program to the address listed below.

6. Examination scores/cerification **sent directly** from the **ARRT or NBTCB** to the Board of Radiologic Technology.
7. **(Endorsement Candidates):** Please send the license verification form on page 10 to all states in which **applicant holds or has held a license**. Be sure to sign and complete the identifying information on the form. HEALTH must receive these verifications **directly** from the licensing authority in each state.
8. Mail the application and documentation to:

**Rhode Island Department of Health  
Board of Radiologic Technology, Room 104  
3 Capitol Hill  
Providence, RI 02908-5097**



# State of Rhode Island Board of Radiologic Technology

## Application for License as a Radiographer, Nuclear Medicine Technologist or Radiation Therapist

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

### 2. Social Security Number

 -  - 

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

### 3. Gender

 Male Female

### 4. Date of Birth

 /  /  **1** **9** 

Month

Day

Year

### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 - 

Home Phone

State

 - 

Zip Code

Postal Code, If NOT U.S.

 - 

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

***This address will appear on the Department of Health web site.***

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 - 

Business Phone

Extension

State

 - 

Zip Code

Postal Code, If NOT U.S.

 - 

Business Fax

**7. Preferred Mailing Address**

Please check ONE

- Please use my **Home Address** as my preferred mailing address
- Please use my **Business Address** as my preferred mailing address

**8. Qualifying Education**

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated:

Month Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

**9. Other State License(s)**

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state?  Yes  No

If the answer to this question is **“yes”**, enter all other state licenses in Question 10 (below):

**10. Licensure**

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	State/Country:	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
	<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive		<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive

**11. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state, or local statute, regulation, or ordinance, or are there any formal charges pending?

Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**12. Disciplinary Questions**

Check either Yes or No for each question.



1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending?

Yes  No

2. Have you ever been denied a license, certificate, registration or permit in any state?

Yes  No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

### 13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully 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 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 license to practice as a Radiographer/Nuclear Medicine Technologist/Radiation Therapist in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Radiologic Technology of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did / did not take an oath.

\_\_\_\_\_  
Name of Notary (Print, Type or Stamp)

\_\_\_\_\_  
Signature of Notary

Notary Seal

\_\_\_\_\_  
Notary No/Commission No.

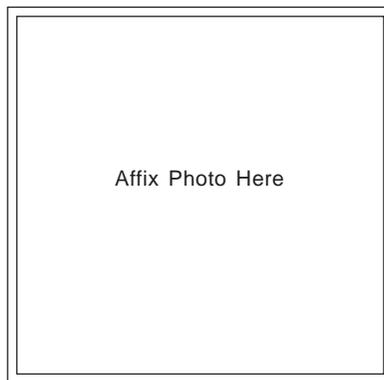
\_\_\_\_\_  
Commission Expiration Date (MM/DD/YY)

### 14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



Write your name on the back of the photograph, and provide the date that the photograph was taken.

\_\_\_\_\_  
Date of Photograph

# APPLICATION CHECKLIST

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Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

## Board Application

- I have read and understand the "Instructions for Completing the Application".
- I have completed the Rhode Island Board application as instructed (pages 5-8).
- I have attached the cover page of the application.
- I have completed Section 13, "**Affidavit of Applicant**", and had the form notarized by a notary public.
- I have attached a photograph to Section 14, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the: "**Rhode Island General Treasurer**" and attached it to the upper left-hand corner of the first (Top) page of the application.
- Supplemental CT Applicants: Application Form on page (13) and an additional **\$50.00** made payable (in U.S. funds only) to the: "**Rhode Island General Treasurer**"
- I have arranged my Board Application materials in the following order.
  1. Fee (attached as instructed).
  2. Board Application (including cover page) and pages 5-8.
  3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] **MUST** indicate the section for which the information is being reported.]
- I have mailed the above application materials directly to the Rhode Island Board of Radiologic Technology.

## Required Forms

- I have completed and mailed the following forms as instructed.
  1. Interstate Verification Form(s) - Other State License(s).

## Additional Documents

- I have requested a school transcript and my examination score, as instructed.



# Rhode Island Board of Radiologic Technology

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2837

Substitute forms are not acceptable, copy this form as needed.

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSURE

I am applying for a license to practice as a Radiographer/Nuclear Medicine Technologist/Radiation Therapist in the State of Rhode Island. The Rhode Island Board of Radiologic Technology requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Radiologic Technology at the above address.

_____	_____	_____
Print/Type Full Name	Signature	Date
_____	_____	_____
Previous Names Used	Social Security Number	Date of Birth
_____	_____	
License Number	Date Issued	

### THIS SECTION TO BE COMPLETED BY THE Radiologic Technology BOARD

License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Specify) _____	Original Date Issued:	Expiration Date:
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**Questions:**

- Has this licensee ever been investigated by your Board?  Yes    No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes    No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes    No
- Do you know of any information that may discredit this person?  Yes    No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Certification:

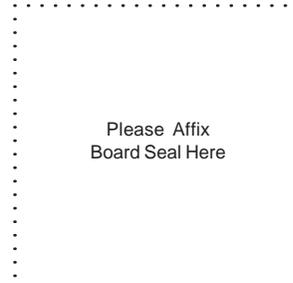
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Full Name and State of Licensing Board



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



# Rhode Island Board of Radiologic Technology

Substitute forms are not acceptable, copy this form as needed.

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2837

## NUCLEAR MEDICINE TECHNOLOGIST VERIFICATION OF CERTIFICATION FORM

I am applying for a license to practice as a Nuclear Medicine Technologist in the State of Rhode Island. The Rhode Island Board of Radiologic Technology requires that applicants for Rhode Island licensure must have this form verified, signed and sealed by the Nuclear Medicine Technology Certification Board, Building I, 3558 Habersham at Northlake, Tucker, GA 30084. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Radiologic Technology at the above address.

Print/Type Full Name _____	Signature _____	Date _____
Previous Names Used _____	Social Security Number _____	Date of Birth _____
License Number _____	Date Issued _____	

### THIS SECTION TO BE COMPLETED BY THE NUCLEAR MEDICINE TECHNOLOGY CERTIFICATION BOARD

The individual named above has made application to the Rhode Island Department of Health, Board of Radiologic Technology, to become licensed as a Nuclear Medicine Technologist. Rhode Island Rules and Regulations for the licensure of Radiographers, Nuclear Medicine Technologists and Radiation Therapists requires these individuals to obtain verification of certification by the Nuclear Medicine Technology Certification Board. This form is provided for that purpose.

This is to certify that \_\_\_\_\_ has completed an accredited program in \_\_\_\_\_

located at \_\_\_\_\_ became certified as a \_\_\_\_\_.

Certification Number: \_\_\_\_\_

Issue Date: \_\_\_\_\_

Is the certification in good standing (if no, please explain)?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Certification:

Signature of Executive Officer \_\_\_\_\_ Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_



Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Please check level of licensure you are applying for:

- \_\_\_ Radiographer
- \_\_\_ Nuclear Medicine Technologist
- \_\_\_ Radiation Therapist
- \_\_\_ Radiologist Assistant



Rhode Island  
Board of Radiologic Technology  
Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

- Diagnostic
- Non-diagnostic

## Supplemental Computed Tomography (CT) Certification Application

Name: \_\_\_\_\_  
Full Name (Please Print or Type)

Current RI License Number: \_\_\_\_\_  
(if applicable)

Home Address: \_\_\_\_\_  
(Number and Street)

\_\_\_\_\_  
(City, State, and Zip Code)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Business Phone)

- I am applying for CT (diagnostic). I am currently certified by the American Registry of Radiologic Technologists (ARRT) in Computed Tomography (CT). I have contacted ARRT to request verification of the CT certification to be sent to the RI Board of Radiologic Technology. I am aware that verification must be sent directly from the ARRT to the RI Board.

**OR**

- I am applying for CT (non-diagnostic). I have provided a copy of my training certificate for this registration.

The fee to apply for either the diagnostic or non-diagnostic CT is fifty dollars (\$50.00), payable to "RI General Treasurer", check or money order.