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. This application form (DH 1006, 10/09) may be used to apply for certification for Basic X-Ray Machine Operator or Basic X-Ray Machine Operator-Podiatric Medicine. Please return all 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://portals2.elsevier.com/portal/portal/FLRadTech) or a substantially equivalent program as described in rule 64E-3.003(1)(d), FAC. 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 which 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, 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).
   - Verification of licensure from each state where you have been disciplined or denied licensure/certification/registration for any health care license including a Radiologic Technology license. (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 COURSE**- 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://srdappsdoh.doh.state.fl.us/RadTech/CeProviders.aspx

5. **DISCIPLINE OR DENIAL OF ANY HEALTH CARE LICENSE/CERTIFICATE/REGISTRATION BY ANY ORGANIZATION**: You must report 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.

6. **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.

7. 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.

8. **ADA REQUESTS**: Please contact the ARRT at 651-687-0048

9. When this application is available online, education, HIV/AIDS course certificate, licensure verifications, felony information and specifically requested documents will need to be mailed to the department.

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. You will receive 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

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 and Basic X-Ray Machine Operator – Podiatric Medicine is 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/

FLORIDA DEPARTMENT OF HEALTH

Application for 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 (1010)**	☐ **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:_____

5. EDUCATION – BASIC X-RAY MACHINE OPERATOR (continued)

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:_____

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 <u>current</u> 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 <u>each</u> 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
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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 the 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 Basic X-Ray Machine Operator or Basic X-Ray Machine Operator-Podiatric Medicine 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 _____

FLORIDA DEPARTMENT OF HEALTH

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 USCS § 666 (A)(13).

Florida Department of Health
Basic X-Ray Machine Operator or
Basic X-Ray Machine Operator-Podiatric Medicine

Name:_____

Last **First** **Middle**

Social Security Number:_____

4052 Bald Cypress Way, Bin # C85
Tallahassee, Florida 32399-3285

FLORIDA DEPARTMENT OF HEALTH

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

FLORIDA DEPARTMENT OF HEALTH

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)

☐ **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: (PROVIDE 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:**_____/_____/_____