

Ohio Department of Health Radiologic License Application

To apply online: <http://www.odh.ohio.gov/licenseapplication>

I. Personal Information (Please Print or Type)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Name First		MI	Last
Social Security Number- Required for Initial Applicants Only				Birth date	
Home Address				City	
State	ZIP	County	Home Telephone Number ()		E-mail Address

II. Radiologic License Category (Indicate one per application)

<input type="checkbox"/> Radiographer	<input type="checkbox"/> Nuclear Medicine Technologist	<input type="checkbox"/> Radiation Therapist
<input type="checkbox"/> General X-ray Machine Operator (GXMO)		
<input type="checkbox"/> Chest Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Skull and Sinus
<input type="checkbox"/> Spine	<input type="checkbox"/> Podiatric Radiography	<input type="checkbox"/> Bone Densitometry

III. Employment Information (Related to the use of radiation)

Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer			
Employer address					
City		State	ZIP	Employer Telephone Number ()	
Job title					
Type(s) of radiological procedures performed					
Supervising physician (<i>Print name</i>)					
Type of practice					
<input type="checkbox"/> Chiropractic Office	<input type="checkbox"/> Mobile Health Care	<input type="checkbox"/> Hospital/Medical Center	<input type="checkbox"/> Educational	<input type="checkbox"/> Podiatric Office	
<input type="checkbox"/> Physician Office	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Out-Patient Clinic/Imaging center		<input type="checkbox"/> Other _____	

IV. Veteran Status / Standard of Ethics

1. Are you a service member or veteran, or the spouse or surviving spouse of a service member or veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" <input type="checkbox"/> Military <input type="checkbox"/> Veteran <input type="checkbox"/> Spouse or Surviving Spouse of a Service Member or Veteran
2. Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" enclose a certified copy of the conviction and indictment.
3. Have you ever been formally notified of any complaints against him/her relative to the practice of radiologic technology? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been denied or had a professional license/certification revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "yes" to any of the above questions, please provide a complete explanation on a separate sheet of paper.

V. Continuing Education (CE)—Renewal Applicants only

Pursuant to rule 3701-72-02 of the Ohio Administrative Code, any person applying to renew a license shall complete twelve (12) classroom hours of continuing education courses approved by the Department specific to the license category held.

Requirements

- CE courses must be specific to radiation safety (eg., quality control, quality assurance, positioning, film processing, etc.)
- Radiographers, Nuclear Medicine Technologists, or Radiation Therapists may submit a copy of their current registration card from the ARRT or NMTCB as proof of meeting the CE requirement

Are you currently registered with the ARRT or NMTCB and in compliance with the CE requirements?

- Yes Submit a copy of your current ARRT or NMTCB card specific to the Ohio license category which you are renewing.
- No Submit copy(s) of your continuing education certificate(s) documenting twelve (12) classroom hours in radiation safety courses.

Renewal Applicants—Skip to Section VIII

VI. Professional Credentials

1. Are you certified by the ARRT, NMTCB, or ACRRT? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" enclose a copy of your current certification card, specific to the category in which you are applying.	
2. Do you hold or did you ever hold a radiologic license issued by the Ohio Department of Health? <input type="checkbox"/> Yes <input type="checkbox"/> No License category _____ License Number _____ Expiration date _____	
3. Do you currently hold a radiologic technology certificate or license from another state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" enclose a copy of your current certificate license.	

VII. Radiologic Technology Education

General X-ray Machine Operators Only: Note: GXMO applicants must submit didactic and clinical course certificates and exam certificate.

Ohio accredited GXMO educational course name or Radiologic Technology College/University name	
Dates Attended (mm/dd/yyyy) From _____ To _____	Enclose Course Certificate
Radiologic Technology Students: Enclose School Transcript	
Ohio accredited GXMO Clinical educational course name	
Clinical Module(s) Completed <i>Check all that apply</i> <input type="checkbox"/> Chest Abdomen <input type="checkbox"/> Extremities <input type="checkbox"/> Skull and Sinus <input type="checkbox"/> Spine <input type="checkbox"/> Podiatric Radiography <input type="checkbox"/> Bone Densitometry	
Dates Attended (mm/dd/yyyy) From _____ To _____	Enclose Course Certificate(s)
Radiologic Technology Students: Enclose signed affidavit from program director	
GXMO exam date	GXMO exam score—submit examination certificate

Non-ARRT or NMTCB Radiographer, Nuclear Medicine Technologist, Radiation Therapist Applicants Only

Name of School	Enclose School Transcript or Diploma	
Dates Attended (mm/dd/yyyy) From _____ To _____	Degree	Major

VIII. Statement of Declaration *Application will not be accepted if this statement is omitted*

_____, affirms that he/she is the person referred to in this radiologic license application, the *Applicant's printed name* statements contained within are accurate and true in every respect; that any omission or incomplete information may result in a delay or denial of approval of your application; and that he/she has read and understands this statement; has read and will abide by the rules and regulation of the State of Ohio relating to licensure; permits the department, or it duly authorized representative, at all reasonable times, to inspect my accreditation; and understands that **all fees are non-transferrable and non-refundable.**
 The applicant agrees to notify the department of any changes that would render the information contained on this application inaccurate.

Signature of applicant	Date
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IX. Application Fee

Submit application along with a check or money order in the exact amount indicated below, payable to TREASURER, STATE OF OHIO to the following address:

Ohio Department of Health, Attn: Revenue Processing, P.O. Box 15278, Columbus, Ohio 43215-0278

Initial Application Fee: \$65.00
Renewal Application Fee: \$45.00
Conversion Application Fee (GXMO to Radiographer): \$15.00

For Office Use Only

R N T G	ARRT/NMTCB	Initial	Date
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