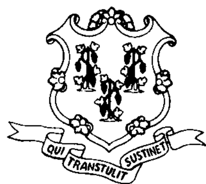

STATE OF CONNECTICUT

RADIOGRAPHER LICENSURE
VERIFICATION OF ARRT STATUS

TO BE COMPLETED BY APPLICANT

APPLICANT*: Complete the top portion of this form and sign the enclosed Authorization, Waiver and Release. Forward both documents to the American Registry of Radiologic Technologists (ARRT), 1255 Northland Dr., St. Paul, Minnesota, 55120 for completion. Please note that if you are not currently registered with the ARRT, this form must be accompanied by a bank check or money order for $60.00 made payable to ARRT. This fee pays for record search and retrieval service and does not confer registration by the ARRT. Registered technologists should not send a fee since this service is covered by the annual renewal fee. ARRT estimates the turnaround time from receipt of your request to the time of mailing to the Department will be three weeks maximum. This assumes that the form contains all required information, including ARRT identification number and signed release form and is accompanied by a $60.00 fee, if applicable.*

NAME: ____
Last First Middle Maiden

ADDRESS: ____
No. & Street City State Zip Code

DAY TIME TELEPHONE NO.: ____________________________ **DATE OF BIRTH**: ____________________

SOCIAL SECURITY NUMBER: _________-_________-________ **ARRT#:** ____________________

Category of exam taken (check one) Radiography ☐ Radiation Therapy Technology ☐

Did you complete a course of study in radiologic technology in a program within the category or categories of the examination noted above which, at the time of your graduation, was accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association? Yes ☐ No ☐.

Signature ____ **Date** ______________________________

TO BE COMPLETED BY ARRT ONLY

Indicate the date on which either of the ARRT examinations listed was passed (leave blank if not passed)
Radiography _________________________ Radiation Therapy Technology _________________________

Check if the individual met the ARRT eligibility requirements as a graduate of an accredited educational program in radiologic technology as noted above: Radiography ☐ Radiation Therapy Technology ☐

If this individual did not complete an accredited educational program in radiologic technology as noted above, did the ARRT deem the educational preparation of this individual equivalent thereto? Yes ☐ No ☐
Radiography ☐ Radiation Therapy Technology ☐

Was this individual registered by the ARRT based on successful completion of the American Registry of Clinical Radiology Technologists Examination? Yes ☐ No ☐. If yes, date certified ____________________

Do the ARRT files contain any derogatory information regarding this individual including, but not limited to, any adverse action taken? Yes ☐ No ☐. If yes, please provide photocopies of relevant documents.

Signature and Title: ____ Date: ______________________

Day time telephone number________________________

Please return this form directly to:

Department of Public Health
Radiographer Licensure
410 Capitol Ave , MS# 12APP
P.O. Box 340308
Hartford, CT 06134--0308

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
RADIOGRAPHER LICENSURE
AUTHORIZATION, WAIVER, AND RELEASE

As an inducement to The American Registry of Radiologic Technologists and its trustees, officers, employees, representatives, and agents, and each and all of them (collectively, its "agents"), to provide information about me freely, fully, and openly to the State of Connecticut Department of Public Health, Bureau of Healthcare Systems, I hereby (1) request and authorize The American Registry of Radiologic Technologists and each and all of its agents, to provide full information (including, without limitation, facts, medical records, opinions, and impressions, both oral and written) concerning me and my education, training, employment, professional and academic performance and conduct, personal and medical history (specifically including, without limitation, my medical, employment, or other records in their possession regarding any actual or recommended treatment or counseling for chemical dependency or substance abuse), and personal characteristics to the State of Connecticut Department of Public Health, Bureau of Healthcare Systems; and (2) waive and release, indemnify, and hold harmless The American Registry of Radiologic Technologists and each and all of its agents who provide any such information concerning me, from, against, and with respect to any and all claims, losses, costs, expenses, damages, liabilities, and judgments of any and every kind or nature whatsoever which arise, or are alleged to have arisen, from, out of, with respect to, or in connection with the provision of any such information concerning me. I understand that my obligations under clause(2)of the preceding sentence are continuing in nature, and cannot be terminated, canceled, or revoked.

I understand and agree that the authorization set forth in clause (1) of the preceding paragraph may be revoked by me at any time; provided, however, that such revocation shall be in writing and sent to The American Registry of Radiologic Technologists by registered United States Mail, return receipt requested; and provided, further, that such revocation shall not affect my obligations under clause (2) of the preceding paragraph nor apply to any disclosure of information made pursuant to clause (I) of the preceding paragraph by The American Registry of Radiologic Technologists or any or all of its agents prior to their receipt of such revocation. This document may be signed by me in multiple counterparts, and, if it is, each such counterpart shall constitute a signed original. A carbon copy, facsimile copy, or other photocopy or reproduction of this document shall be as valid and binding as a signed original.

Typed or Printed Name ____

Signature ____________________________________ Date _____________________________

Department of Public Health
Radiographer Licensure
410 Capitol Ave
MS# 12APP • P.O. Box 340308
Hartford, CT 06134--0308
(860) 509-7603 • web-site www.dph.state.ct.us