

Login

Medical Radiologic Technologist Licensure Application

Notice for Military and Veteran Applicants:

Senate Bill 807, which became effective on September 1, 2015, allows for the waiver of application fees for any US military service member, active duty military spouse or military veteran. If you would like to be pre-qualified for this exemption, please visit this link to obtain the fee waiver request form: Military Fee Waiver. Follow the instructions, and once submitted to the Board, allow 3 business days for processing. Approved waivers will be notified by email to proceed completing the online application.

Approved Pre-Qualified Military and Veteran Applicants:

If you have already received your pre-qualification email and have been issued a 6 digit Medical Board ID number, please continue through the application. If you are re-directed to TX.gov for payment, please double-check the Date of Birth and SSN number entered and make any corrections before re-submitting. If you are still re-directed to Texas.gov for payment, contact us at: Screen-CIC@tmb.state.tx.us

Information you enter will be automatically saved at the end of every page.

- You must complete the application with 15 days or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit it, along with any relevant records.
- Pay the license fee using one of the following:
 - MasterCard,
 - Visa,
 - Discover,
 - American Express, or
 - Electronic Check.

Please enter the following information carefully as it will be used to track your application and allow you to access it again.

Asterisk (*) indicates response required.

Email Address:

Date of Birth (MM/DD/YYYY)*:

Alternate Text displayed for unfinished application:

Our records indicate that within the last 15 days, you began the online application process. Any updates made at that time were saved. Would you like to use this saved information or start the application process over? Click the "Use Recent Updates" button to use updates made within the last 15 days, otherwise click the "Start Over" button.

Identification

You are applying for the Medical Radiologic Technologist License. Please be advised that a false response to any question may be grounds for the denial of your application for a permit and such denial may be made public and reported to other authorities.

Asterisk (*) indicates response required.

Full Name as you wish it to appear on your receipt*:

First Name*:

Middle Name:

Last Name*:

Date of Birth (MM/DD/YYYY)*:

Email Address:

Social Security Number (XXX-XX-XXXX or XXXXXXXXX)*:

Are you currently on active duty in the U.S. Military?*

An applicant headquartered in Texas who is an active duty military service member, or the spouse of an active duty military service member, may be eligible for expedited handling. If you think you may qualify please select the appropriate box:

Military Service Member (active duty):

Spouse of a Military Service Member (active duty):

Address Information Section

Please provide your mailing and daytime U.S. phone number. It is your responsibility to notify the Board in writing if you have a change of address.

All correspondence will be sent to the mailing address. When entering a foreign address, leave the State blank and provide a Country.

Asterisk (*) indicates response required.

Mailing address

Mailing Address 1*:

Mailing Address 2:

Mailing City*:

Mailing State*:

Mailing ZIP Code*:

Mailing Country*:

Telephone Number ###-###-####*:

Credentials

Asterisk (*) indicates response required

Are you certified by a national organization (Registry) that attests to your competency as an operator of radiation or radiation emitting equipment?
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<input type="radio"/> Yes <input type="radio"/> No

Please list all professional credentials you hold, including American Registry of Radiologic Technologists (ARRT) and Nuclear Medicine Technology Certification Board (NMTCB).

National Organization:

Certificate Number:

Type:

Issue Date (MM/YYYY)*:

Licenses

Please list all other health care license(s), registration(s) that you possess or have possessed e.g. (RN/LVN/PT/AT/EMT/ECA/other).

State/Territory:

Title of Certificate or License:

Number:

Issue Date (MM/YYYY)*:

Work History

- Please account for all periods of work from the time you graduated from your medical radiologic technology program to the present date.
- Include all periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today's date as an end date.

Add Work Experience

Add Work History

Asterisk (*) indicates response required.

Position*:
Department*:
Start Date (MM/YYYY)*:
End Date (MM/YYYY)*:
Facility/Employer
Name*:
Street*:
City*:
State:
ZIP/Postal Code*:
Province:
Country*:
Phone Number:

Questions

Asterisk (*) indicates response required

If you have completed a degree at an accredited college or university, please enter it below

Type of Degree:

Your name at time of graduation:

First Name:

Middle Name:

Last Name:

Name of College or University:

City of College or University:

State of College or University:

License Type:

Please choose the license type for which you are applying:

General Certificate	
Applicant currently holds or has successfully completed national certificate as a Certified Nuclear Medicine Technologist by the Nuclear Medicine Technology Certification Board (NMTCB).	
Temporary General Certificate	

Limited Certificate	
<p>Applicant has successfully passed the American Registry of Radiologic Technologists (ARRT) examination for one or more of the following categories. Please check the categories which you have passed and attach examination paper work with application.</p> <p>Please Note - In order to qualify for the cardiovascular LMRT certification, you must have passed the Cardiovascular Credentialing International invasive registry examination AND completed an accredited invasive cardiovascular program</p>	
Cardiovascular Category	
Chest Category	
Extremities Category	
Skull Category	
Spine Category	
Podiatric Category	

Temporary Limited Certificate	
<p>This is a one year license and cannot be renewed.</p> <p>Applicant is a graduate of a radiologic technology program (limited curriculum) approved by the Department of State Health Services in the categories checked, as follows:</p> <p>Or:</p> <p>Applicant is expected to graduate within 28 calendar days from a radiologic technology program (limited curriculum) approved by the Department of State Health Services in the categories checked, as follows:</p>	
Chest Category	
Extremities Category	
Skull Category	
Spine Category	

Arrest/Criminal History

This is important.

The Board will run queries with the Texas Department of Public Safety and the FBI to verify your criminal history. Both entities maintain records, often beyond the time that courts keep them. Please be aware that if you have **ever** been arrested, charged, or convicted of a misdemeanor or a felony, the record of those events will be reported as a result of the fingerprint inquiry.

Serious traffic offenses such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked **MUST** be reported. This list is not all-inclusive. If in doubt as to whether an offense should be disclosed, it is better to disclose the offense on the application.

Matters in which you were diverted, deferred, pardoned, or pled nolo contendere MUST be disclosed.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

If you are in doubt as to how to respond to the questions, full and honest disclosure is highly recommended.

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See Form R.

Question 1*

Have you ever been arrested?	<input type="radio"/> Yes <input type="radio"/> No
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Question 2*

Have you ever been charged with any violation of the law regardless of outcome? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less).	<input type="radio"/> Yes <input type="radio"/> No
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Question 3*

Are you currently the subject of a grand jury or criminal investigation?	<input type="radio"/> Yes <input type="radio"/> No
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Question 4*

Have you ever been placed on probation?	<input type="radio"/> Yes <input type="radio"/> No
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Question 5*

Have you ever been granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of \$250 or less.)	<input type="radio"/> Yes <input type="radio"/> No
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Question 6*

Have you ever been convicted of an offense or imprisoned?	<input type="radio"/> Yes <input type="radio"/> No
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Mental and Physical Health

If you answer “Yes” to the following question, you are required to submit Form W.

Question 7*

Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?	<input type="radio"/> Yes <input type="radio"/> No
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The Texas Physician Health Program (TXPHP) is a confidential program that promotes wellness and the treatment of health conditions that may compromise the ability to practice with reasonable skill and safety. TXPHP is a resource available for all licensees who may suffer from a condition that is or could impair their ability to practice.

TXPHP does not itself treat those who participate, but facilitates a participant’s treatment and provides monitoring as needed. Examples of conditions that TXPHP can monitor include: substance abuse and addiction issues, mental health issues, and other medical conditions that may interrupt a licensee’s practice. In addition to monitoring, TXPHP provides education, recognition, and assistance in diagnosis, treatment, and management of licensees’ potentially impairing conditions.

You may contact TXPHP for further information on the program by calling (512) 305-7462 or via email at info@txphp.state.tx.us. Downloadable self-report forms can be found on the TXPHP website, <http://www.txphp.state.tx.us/>, under the “Forms” section of the website.

Attestation

I affirm that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein, and evidence or other credentials submitted herewith, are true and correct; that I am the lawful holder of the required certificate and/or educational degree as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, was procured without fraud or misrepresentation or any mistake of which I am aware.

Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business or professional associates (past, present and future) and all governmental agencies (local, state, federal, or foreign) to release , to the Texas Medical Board or its successors, any information, files or records, including medical records, educational and training records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application, necessary to determine my professional competence, professional conduct, or physical and/or mental ability to safely engage in the practice as a certified radiological technologist. Any materials submitted to the Board in connection with this application process become the property of the Texas Medical Board and will not be returned. I acknowledge that the Board may release any information or materials, submitted to the Board in connection with this application process, to others as allowed or required by state or federal law.

I hereby affirm that I will provide the Board with updated information to be received by the Board within 15 days of my becoming aware of any event that occurs after submission of my application that renders any response, although complete and correct when made, no longer complete or correct. Further, I understand that failure to provide updates may result in an adverse action against my application.

I understand that falsification or misrepresentation of any item or response on this application or any supplemental information is a sufficient basis for a denial or revocation of a license, a determination of ineligibility, or another adverse action against my application or my license after issuance. I hereby affirm that I have read and agree to abide by the specific laws and rules associated with a license to practice certified radiologic technology in this state.

I agree to these terms.

The applicant checks a box to indicate agreement and cannot continue to payment until they do.