State of Hawaii
Radiologic Technology Board

APPLICATION FOR LICENSURE IN RADIOLOGIC TECHNOLOGY

License is required by Title 11, Administrative Rules, Department of Health, Chapter 44, Radiologic Technology Rules.

Requesting Licensure As: **Radiographer** ☐ **Radiation Therapist** ☐ **Nuclear Medicine Technologist** ☐

Part I. Applicant Information

_____ _____
Last Name First Name MI Social Security Number (Last Four)

_____ _____
Mailing Address Date of Birth

_____ Telephone_____ / _____
City State Zip Code Home Business

Present Employer_____
Name

_____
Street Address City State Zip Code

Part II. Certification

1. **Radiographers and Radiation Therapists:** Provide a copy of your current American Registry of Radiologic Technologists (ARRT) membership card.

2. **Nuclear Medicine Technologists:** Provide a copy of your current ARRT membership card **OR** verification of current certification from the Nuclear Medicine Technology Certification Board (NMTCB).

Part III. Personal Information

1. Have you ever been discharged from school or employment because your conduct or work was not satisfactory? **Yes / No**

2. Have you ever been arrested and convicted for any violation of any federal, state, county, or municipal law, regulation, or ordinance? (This does not include traffic violations for which a fine of $50.00 or less was imposed, nor any incidents before your 16th birthday). **Yes / No** If **YES** to any of the above questions, provide a complete explanation on a separate sheet.

FOR OFFICE USE ONLY

Date Received:_____ Fee Paid $_____ Receipt Number:_____

Circle Appropriate Certification: ARRT-R ARRT-T ARRT-N NMTCB

Application: Approved / Disapproved Date:_____ CSEA List Dated:_____

License Type & Number: Radiographer **R-**_____ Effective Date_____

Radiation Therapist **T-**_____ Effective Date_____

License(s) Expire:_____ Nuclear Med Tech **N-**_____ Effective Date_____

Part IV. Attestation

Attach a photograph of yourself (head and shoulders only) taken within the last six months. This photograph will be used for identification purposes.

In consideration of the granting to me a license or the renewal thereof, and the attendant right to use the title "Certified Radiographer" or "Certified Radiation Therapist," or "Certified Nuclear Medicine Technologist," according to the appropriate license issued, in connection with my name, I do hereby agree to perform the duties of a radiologic technologist and to abide by all rules of the Radiologic Technology Board as they apply to my profession.

I hereby authorize the Board to release information provided on this application to the American Registry of Radiologic Technologists or the Nuclear Medicine Technology Certification Board. I also authorize the Board to identify me and to report the fact of my licensure or non-licensure in radiologic technology to prospective employers, universities, colleges, schools, federal, state, and local agencies, hospitals, health departments, and similar organizations and agencies.

I do hereby attest that I am not presently practicing as a radiologic technologist (i.e., radiographer, radiation therapist, or nuclear medicine technologist) in the State of Hawaii, and affirm that I shall not do so unless and until a valid license (i.e., Certified Radiographer, Certified Radiation Therapist, or Certified Nuclear Medicine Technologist) has been issued to me under the provisions of Title 11, Hawaii Administrative Rules, Chapter 44, Radiologic Technology Rules.

I am aware that violators of this chapter and of Chapter 466J, Hawaii Revised Statutes, including anyone who practices or offers to practice as a radiologic technologist (i.e., radiographer, radiation therapist, or nuclear medicine technologist) without a valid and effective license issued by the Radiologic Technology Board, are subject to the penalties described in Chapter 466J, Hawaii Revised Statutes.

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I also declare that all the information appearing on this application is accurate and true to the best of my knowledge.

_____
Applicant's Signature Date

Notary Seal

Witnessed this _____day of _____ 20_____

_____
Notary Public's Signature Date

Notary: Please note: Photograph of applicant must be attached above when applicant's signature is witnessed.

Fee: **$60.00** (1 license) **$65.00** (2 licenses) **$70.00** (3 licenses) (All fees are non-refundable)

Please make checks payable to: **STATE DEPARTMENT OF HEALTH**

Return this application with the appropriate documents to:

Radiologic Technology Board
c/o Department of Health
Indoor and Radiological Health Branch
99-945 Halawa Valley Street
Aiea, HI 96701

There will be a service fee of $25.00 for any check dishonored by the bank.