Ohio Department of Health
Radiologic License Application

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

I. Personal Information (Please Print or Type)

☐ Mr. ☐ Mrs. ☐ Ms.	Name (First)	(MI)	(Last)
Social Security Number- Required for Initial Applicants Only		Birth Date (mm/dd/yyyy)	
Home Address		City	

State	ZIP	County	Home Telephone Number	E-mail Address
			( )	

II. Radiologic License Category (Indicate one per application)

☐ Radiographer ☐ Nuclear Medicine Technologist ☐ Radiation Therapist

☐ General X-ray Machine Operator (GXMO)

☐ Chest Abdomen ☐ Extremities ☐ Skull and Sinus ☐ Spine ☐ Podiatric Radiography ☐ Bone Densitometry

III. Veteran Status

Are you a service member or veteran, or the spouse or surviving spouse of a service member or veteran?

☐ Yes ☐ No

If "Yes"

☐ Military ☐ Veteran ☐ Spouse or Surviving Spouse of a Service Member or Veteran

Submit one of the following documents as proof of service:

☐ Department of Defense identification card (Active, Retired, temporary disability retirement list (TDRL)

☐ DD214 military discharge certificate indicating disposition of discharge

☐ Report of separation from the national archives national personnel records in St. Louis, Missouri

☐ Veterans identification card from the Department of Veteran's Affairs

IV. Standard of Ethics

1. Have you ever been convicted of a felony?

☐ Yes ☐ No **If "Yes" enclose a certified copy of the conviction and indictment.**

2. Have you ever been formally notified of any complaints against him/her relative to the practice of radiologic technology?

☐ Yes ☐ No

3. Have you ever been denied or had a professional license/certification revoked?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please provide a complete explanation on a separate sheet of paper or use the last page of this document to type your explanation.

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) CE credits approved by the Department specific to the license category held. Beginning June 1, 2019 radiographers, nuclear medicine technologists, and radiation therapists applying to renew shall complete twenty-four (24) CE credits.

Requirements

• CE courses must be specific to radiation safety (e.g., 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 CE certificate(s) documenting twelve (12) CE credits in radiation safety courses.

Renewal Applicants—Skip to Section VIII

VI. Professional Credentials

1. Are you certified by the ARRT, NMTCB, or ACRRT?
☐ Yes ☐ 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?
☐ Yes ☐ No License Category_____ License Number_____ Expiration Date (mm/dd/yyy) _____

3. Do you currently hold a radiologic technology certificate or license from another state?
☐ Yes ☐ 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 (*Check all that apply)* ☐ Chest Abdomen ☐ Extremities ☐ Skull and Sinus ☐ Spine ☐ Podiatric Radiography ☐ 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 (mm/dd/yyyy)	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 (mm/dd/yyyy)

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 (mm/dd/yyyy)