INSTRUCTIONS

(1) Print legibly and complete the form. Illegible or incomplete forms will be returned.

(2) Have your signature notarized.

(3) Include a photocopy of your current ARDMS or NMTCB credential card with this form.

(4) Mail the original form (photocopies not accepted) to ARRT, Initial Certification Department, 1255 Northland Drive, St Paul, MN 55120-1155

(5) Online account access forms are processed within a few days of receipt by ARRT. You will receive notification and access instructions via mail with 7 to 12 business days.

(6) Contact the Initial Certification Department with questions: 651.687.0048, ext. 8560.
Read instructions in this document before completing this application.

Name on application must be legal name and match name on two IDs presented at test center. See handbook for details.

Last Name

First Name

Middle Name or Initial

Street Address 1

Street Address 2

City

State/Prov

Zip/PC

Birthdate

MO

DA

YR

U.S. Social Security Number

No SSN

(Male)

(Female)

Have you previously submitted an application for ARRT certification and registration in radiography, nuclear medicine technology, radiation therapy, sonography or magnetic resonance imaging, or a pre-application to determine eligibility?

No

Yes

If “yes,” provide your ARRT number and any previous names.

ARRT ID Number

Previous Name

Complete all information above and attach photo. Then bring form to a notary office to have them complete the information below. In the presence of the notary, add your signature below.

NOTARY

NOTARY, PLEASE NOTE: Photograph of candidate must be attached prior to notarizing.

Before me personally appeared

to me known to be the person described in the above application, who signed the foregoing instrument in my presence, and made oath before me to the accuracy of the statements set forth herein, on the ____________ day of ____________________, 20________.

__________________________________________________

(Applicant Signature)

NOTE: The declaration below must be signed in the presence of a Notary Public.

I DECLARE THAT ALL THE DATA APPEARING ON THIS APPLICATION ARE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

__________________________________________________

(Applicant Signature)

THE AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS® | Online Account Access Form

DO NOT WRITE IN THE SPACE BELOW. FOR OFFICE USE ONLY. Verified by: Input by:

INCODE:

Fee received:

Page 2 of 2

FORM JULY 2017