

# AMERICAN CHIROPRACTIC REGISTRY OF RADIOLOGIC TECHNOLOGISTS

Registry Number - ACRRRT use only

**Application Fee - \$240.00**

**FEE WILL NOT BE REFUNDED**

Please type or print legibly

<b>Name</b>	Last	First	Middle Initial
<b>Permanent Address</b>	Street Address		
	City	State	Zip
<b>Mailing Address (if different)</b>	Street Address		
	City	State	Zip
<b>Phone</b>	Home	Work	Email
	Birth Date - month / day / year		Birth State
<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>	Birth City		

Please answer the following questions

Have you ever been convicted of a felony?	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, give complete explanation on separate sheet.
Have you previously submitted an application to the ACRRRT?	Y <input type="checkbox"/> N <input type="checkbox"/>	
Have you previously been examined by the ACRRRT?	Y <input type="checkbox"/> N <input type="checkbox"/>	
Are you certified with any other registry in radiography?	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, identify which registry
		Registry number
Are you certified/licensed by any state or regulatory agency?	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, indicate which agency
		License/permit number

\* Your education and background in Radiography is required

<b>Formal Training</b>	Institution		Location	
	Degree		Certificate	
	Attended From - month / day / year	To - month / day / year	Date (to be) Awarded - month / day / year	
<b>Practical Training</b>	Institution or Facility		Location	
	Supervisor		From - month / day / year	To - month / day / year

<b>Indicate test site desired</b>	Location
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(OVER)

# ENDORSEMENT

<b>*Applicant has/will have completed the approved educational program on:</b>		Date    month / day / year	
Program Director Signature	Title	Date    month / day / year	
Street Address	City	State	Zip

<b>Applicant has functioned as a Radiological Technologist in my/our office(s) on those dates indicated.</b>			
Physician Signature	Title	Date    month / day / year	
Physician Signature	Title	Date    month / day / year	

\*If all phases of the educational program have been completed on the date of the above endorsement, no institutional authorization form is required. However, all other endorsements must be signed and dated.

<b>AGREEMENT</b>	
In consideration of the granting to me a Certificate of Registration, or the renewal thereof, and the attendant right to use the title "Registered Radiologic Technologist" and its abbreviation, "R.T.(ACRRT)", in conjunction with my name, I do hereby agree to perform the duties of a Chiropractic Radiologic Technologist only under the direction of a person whose qualifications are acceptable to this Registry; to abide by the rules and regulations of the American Chiropractic Registry of Radiologic Technologists as they apply to my profession and to conduct myself in a manner appropriate to the dignity of my profession.	
I hereby authorize the Registry to identify me and to report on request, the fact of my certification or non-certification in radiography to prospective employers, universities, colleges, schools, state and local agencies, hospitals, health departments, and similar organizations and agencies.	
I understand that the application fee is <b>\$240.00</b> and that this fee will NOT be refunded.	
I declare that all data appearing on this application is accurate and true to the best of my knowledge.	
_____	_____
Signature of Applicant	Date    month / day / year

Send completed application with non-refundable **\$240.00** application fee to:  
**ACRRT**  
**52 W. Colfax Street**  
**Palatine, IL 60067**

Before me personally appeared \_\_\_\_\_, known to me to be the person described in the above application for examination, who signed the foregoing instrument in my presence and made oath or affirmation before me as to the accuracy of the statements set forth therein, on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

This photograph will be used in conjunction with your application for examination for certification. It will not be made available to any person who grades your examination nor to any person who makes any decision concerning employment.

Notary Signature \_\_\_\_\_

My commission expires: \_\_\_\_\_, 20 \_\_\_\_\_

**PHOTOGRAPH**

**NOTICE TO NOTARY**

Photograph of the applicant must be attached here when the signature is witnessed.

Applicant: Staple a photograph of passport quality here which was taken within the last six months.

**NOTARY SEAL**