AMERICAN CHIROPRACTIC REGISTRY OF RADIOLOGIC TECHNOLOGISTS

Registry Number - ACRRT use only

Application Fee - $245.00 **FEE WILL NOT BE REFUNDED**

Please type or print legibly

Name	**Last**		**First**	**Middle Initial**
Permanent Address	**Street Address**			
	City		**State**	**Zip**
Mailing Address (if different)	**Street Address**			
	City		**State**	**Zip**
Phone	**Home**	**Work**		**Email**
Sex M ☐ F ☐	**Birth Date - month / day / year**	**Birth City**		**Birth State**

Please answer the following questions

Have you ever been convicted of a felony?	**Y** ☐ **N** ☐	**If yes, give complete explanation on separate sheet.**
Have you previously submitted an application to the ACRRT?	**Y** ☐ **N** ☐	
Have you previously been examined by the ACRRT?	**Y** ☐ **N** ☐	
Are you certified with any other registry in radiography?	**Y** ☐ **N** ☐	**If yes, Identify which registry** Registry number
Are you certified/licensed by any state or regulatory agency?	**Y** ☐ **N** ☐	**If yes, indicate which agency** License/permit number

*** Your education and background in Radiography is required**

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

Indicate test site desired	Location

(OVER)

ENDORSEMENT

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

Applicant has functioned as a Radiological Technologist in my/our office(s) on those dates indicated.		
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.

AGREEMENT

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 **$245.00** 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 **$245.00** application fee to:

ACRRT
52 W. Colfax Street
Palatine, IL 60067

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.

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 _____.

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