

# AMERICAN CHIROPRACTIC REGISTRY OF RADIOLOGIC TECHNOLOGISTS

Registry Number - ACRRT use only

**Application Fee - \$180.00**

**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	Fax
	Birth Date - month / day / year		Birth City
<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>	Birth Date - month / day / year		Birth State

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 ACRRT?	Y <input type="checkbox"/> N <input type="checkbox"/>	
Have you previously been examined by the ACRRT?	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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