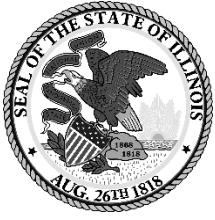


Please read entire content as it pertains to changes in Part 401 in regards the limited scope examination.  
**ARRT is only accepting payment by credit card. Instructions will be sent upon acceptance and processing of application.**

The completed and signed application can be sent by email to [ema.radtech@illinois.gov](mailto:ema.radtech@illinois.gov) or faxed 217-785-9946. Once the application is received and processed an email will be sent with a link on how to pay the \$150 fee directly to ARRT. You will not need to mail us anything.



# ILLINOIS EMERGENCY MANAGEMENT AGENCY

## Application for Examination in Limited Radiography

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1. The application must be complete, signed and legible. Print or type all information.
2. The \$150 fee is payable to ARRT by credit card. Payment instructions will be emailed after processing application. Application fees are non-refundable.
3. Please email (ema.radtech@illinois.gov) or fax (217-785-9946) the completed application.
4. If you have any questions, please call 217-785-9913.

Social Security Number: _____	Birthdate: _____	
Name: _____ Last First MI	Business Telephone: _____	
Address: _____ City State Zip	Home/Cell Telephone: _____ Email (Required): _____ <i>Grades will be sent electronically</i>	
Application for: <input type="checkbox"/> Exam <input type="checkbox"/> Re-exam		
Check the appropriate categories for which you wish to be examined: <input type="checkbox"/> Chest <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Skull and Sinuses		
Month and year you wish to be examined: _____ Please allow approximately 3 weeks for scheduling exam. (mm/yyyy)		
<b>SUPERVISION ATTESTATION</b>		
Personal (in the room) supervision of the trainee is required during a radiographic procedure. As such, only a licensed physician or Agency accredited radiographer may initialize the x-ray exposure.		
Physician Acknowledgment:		
_____	_____	_____
Printed Name	Signature	Date
<b>EMPLOYER INFORMATION</b>		
Facility Registration #: _____		
Name of Facility: _____		
Address/City/Zip: _____		
_____	_____	
Applicant Signature	Date Application Signed	