



THE SOUTH CAROLINA RADIATION QUALITY STANDARDS ASSOCIATION

P.O. Box 7515 • Columbia, SC 29202 • Telephone (803) 771-6141 • Facsimile (803) 771-8048 • www.scrqsa.org

APPLICATION FOR CERTIFICATION

CERTIFICATIONS OFFERED

- | | |
|--|--|
| <input type="checkbox"/> Radiography (ARRT)** | <input type="checkbox"/> Limited Practice Radiographer-General |
| <input type="checkbox"/> Radiography (Non-ARRT) | <input type="checkbox"/> Limited Practice Radiographer-Chest |
| <input type="checkbox"/> Nuclear Medicine Technology (ARRT or NMTCB)** | <input type="checkbox"/> Limited Practice Radiographer-Podiatric |
| <input type="checkbox"/> Radiation Therapist (ARRT)** | <input type="checkbox"/> Limited Practice Radiographer-Chiropractic |
| <input type="checkbox"/> Radiation Therapist (Non-ARRT) | <input type="checkbox"/> Bone Densitometry Operator (ISCD) |
| <input type="checkbox"/> Invasive Specialist (ARRT, RCIS)** | <input type="checkbox"/> Bone Densitometry Operator |
| <input type="checkbox"/> PET (NMTCB)** | <input type="checkbox"/> Limited Bone Densitometry Operator-Peripheral |
| <input type="checkbox"/> Computed Tomography/CT (ARRT)** | |
| <input type="checkbox"/> Invasive Specialist (ARRT, RCIS)** | |

****Individuals qualifying as ARRT, NMTCB, ISCD, PET, CT or RCIS certified must include a copy of the current ARRT, NMTCB, ISCD or RCIS certification card.**

APPLICATION FEE IS \$50.00 for two-year certification cycle (regardless of the number of categories checked). Please make checks payable to the SCRQSA. Fee is NOT refundable. Payment of fee is not deductible as charitable contribution but may qualify as an employee business expense deduction on your personal tax return. For more information, contact IRS Service Center (1-800-829-1040).

IMPORTANT NOTICE: Failure to provide complete and accurate information in each of the spaces provided or failure to include the correct fee will result in an incomplete application. Incomplete applications are returned and penalties will be applied. It is the individual's responsibility to notify the SCRQSA within 30 days of a change of address in writing.

Last Name _____		First Name _____		M.I. _____
<i>Please Print Clearly or Type</i>				
Home Mailing Address _____				<input type="checkbox"/> Please check here if new address or name change.
City _____		State _____	Zip _____	
Home Phone Number _____		SCRQSA Certificate # _____		
Birthdate and Social Security must be provided for purposes of positive identification.				
MO	DAY	YR	SOCIAL SECURITY NUMBER	
EMPLOYMENT FACILITY				Employer's Phone Number _____
<input type="checkbox"/> Check if more than one place of employment		<input type="checkbox"/> Check here if wish to be excluded from the online directory of certificate holders		
Signature of applicant (not valid without signature) _____			Date _____	
For Credit Card Payments:		Please circle credit card type: Master Card Visa		
Card Number: _____		Expiration Date: _____		
Signature of Card Holder: _____				
FOR OFFICE USE ONLY: _____ Check/Money Order Number _____ Amount Paid v. 01/2007				