



APPLICATION FOR RECERTIFICATION

CATEGORY (Check categories for renewal)	
<input type="checkbox"/>	Radiography (ARRT)**
<input type="checkbox"/>	Radiography (Non-ARRT)
<input type="checkbox"/>	Nuclear Medicine Technology (ARRT or NMTCB)**
<input type="checkbox"/>	Radiation Therapist (ARRT)**
<input type="checkbox"/>	Radiation Therapist (Non-ARRT)
<input type="checkbox"/>	Limited Practice Radiographer-General
<input type="checkbox"/>	Limited Practice Radiographer-Chest
<input type="checkbox"/>	Limited Practice Radiographer-Podiatric
<input type="checkbox"/>	Limited Practice Radiographer-Chiropractic
<input type="checkbox"/>	Bone Densitometry Operator (ISCD)
<input type="checkbox"/>	Bone Densitometry Operator
<input type="checkbox"/>	Limited Bone Densitometry Operator-Peripheral
<input type="checkbox"/>	Invasive Specialist

****Individuals qualifying as ARRT, NMTCB, or ISCD certified must include a copy of the current ARRT, NMTCB or ISCD certification card for the renewal process.**

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.

Last Name _____		First Name _____		M.I. _____
<i>Please Print Clearly</i>				
Home Mailing Address _____				<input type="checkbox"/> Please check here if new address

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				
Signature of applicant _____			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 _____				