Public Health
Iowa HHS

Radiologic Technologist Requalification Worksheet

Please submit supporting documentation

___ Iowa Permit to Practice # _____

___ General Certification - ARRT or ARCRT

___ Documentation of 40 hour training (any (1) of the folllowing)

__ ARRT(M) (can't use if date is 4/28/99 to 1/1/01)
__ In house Program
__ Other approved program
Name_____

___ 25 supervised patients

___ 15 mammography specific CEU's

For State of Iowa use:

REQUALIFICATION DATE_____

INITIAL QUALIFICATION START DATE_____
(10/01/94 or date initial qualification was completed)

ADDITIONAL MODALITY START DATE_____
(8 hours initial training in each additional mammographic modality)

NAME OF TECHNOLOGIST_____

PLACE OF EMPLOYMENT_____

LOCATION OF TRAINING_____

NAME OF TRAINER_____**PP#** _____

HHS Approval _____

Date _____