Bureau of Radiological Health

Limited Radiography Training Manual

Public Health

Iowa HHS

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PURPOSE: The Iowa Department of Health and Human Services (HHS) has established the minimum training standards for limited radiologic technologists. This guide should aid in making application for a training program that will meet HHS standards. It will also assist in developing the curriculum and classroom and clinical training. This guide does not apply to x-ray equipment operators in podiatry or bone densitometry. The appendices to this guide serve to provide additional information on specific subject areas. Model procedures that the applicant may adopt are provided. The applicant may use the model procedures as an outline to develop alternative procedures for review by the HHS staff. After review of this guide, if you have specific questions, you may contact:

The Iowa Department of Health and Human Services, Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street
Des Moines, Iowa 50319-0075
Or, you may call 515-371-9398

APPLICABLE REGULATIONS

In addition to 641-chapter 42(136C), other regulations pertaining to the technologist are found in Chapters 38, 40, and 41 of the HHS Radiation Machines and Radioactive Materials Rules. You can find the electronic version by going to https://hhs.iowa.gov/radiological-health

DEFINITIONS

"**Radiologic technologist**" means an individual, excluding x-ray equipment operators in podiatry and bone densitometry, who performs radiography of the human body as ordered by an individual authorized by Iowa law to order radiography.

"**General radiologic technologist**" performs radiography of any part of the human body.

"**Limited radiologic technologist**" performs radiography for the chest, spine, extremities, shoulder or pediatrics, excluding CT and fluoroscopy.

"**Radiography**" means a technique for generating and recording an x-ray pattern for the purpose of providing the user with an image(s) during or after termination of the exposure.

"**Student**" means an individual enrolled in and participating in formal education.

"**Chest**" allows the permit holder to perform radiography of the lung fields including the cardiac shadow, as taught in the limited radiography formal education standards. Chest radiograph techniques shall not be manipulated for the evaluation of the shoulder, clavicle, scapula, ribs, thoracic spine and sternum.

"**Extremities**" allows the permit holder to perform radiography for body parts from:

1. The distal phalanges of the foot to the head of the femur, including its articulation with the pelvis girdle. True hip radiographs are prohibited.
2. The distal phalanges of the hand to the head of the humerus. The radiograph shall not include any of the views in the shoulder category unless the individual holds a limited permit that includes the shoulder category. .

"**Spines**" allows the permit holder to perform radiography of the spine in approved areas only: Cervical vertebrae, thoracic (dorsal) vertebrae, and lumbar vertebrae to include the articulations with the sacrum and coccyx and the sacral articulation with the pelvic girdle. True pelvis radiographs or other projections performed with the image receptor positioned perpendicular to the long axis of the torso are prohibited under this category.

"**Shoulder**" allows the permit holder to perform radiography of the shoulder in the approved projections only. Approved projections and limitations are described as:

(1) AP internal and external rotation.
(2) AP neutral.
(3) Transthoracic lateral views.
(4) Scapular "Y" lateral.
(5) The image may not include the proximal end of the clavicle on any AP projection. All other shoulder views are prohibited. The permit holder must hold a limited radiologic technologist permit with a category of either chest or extremity in order to be granted the shoulder category.

Excerpted from Chapter 42 Rules.

641—42.31(136C) Standards for formal education for limited radiologic technologists.

42.31(1) The formal education may be a single offering that meets all standards of all categories, or it may be offered individually specific to the category the provider wishes to offer.

42.31(2) The following are the minimum standards:

a. A principal instructor shall:

(1) Be an Iowa-licensed chiropractor teaching spine and extremities categories only; or

(2) Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or

(3) Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

b. A clinical instructor shall:

(1) Be an Iowa-licensed chiropractor teaching spine and extremities categories only; or

(2) Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or

(3) Be an Iowa-permitted limited radiologic technologist in the category of instruction and have at least two years of current experience in radiography; or

(4) Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

c. Clinical instructors shall be supervised by the principal instructor.

d. A principal instructor may also act as clinical instructor, if applicable.

e. Classroom and clinical standards are listed below:

Category	Classroom Hours	Clinical Practice Projections	Clinical Competency Projections
Core: Completed by ALL trainees	60		
Chest	20	30 (PA or Lateral)	5 PA & 5 Lateral
Upper Extremities	20	30 (Any Projection)	10 (Only 2 of any projection allowed)
Lower Extremities	20	30 (Any Projection)	10 (Only 2 of any projection allowed)
Shoulder	20	20 (Any Projection)	6 (Only 2 of any projection allowed)
Spine	20	30 (Any Projection)	10 (Only 2 of any projection allowed)
*Pediatric: add on to chest	8 of initial pediatrics	20 (any projections)	2 PA & 2 Lateral
*Pediatric: add on to upper extremities	8 on initial pediatrics	20 (any projections)	10 (Only 2 of any projection allowed)
*Pediatric: add on to lower extremities	8 of initial pediatrics	20 (any projections)	10 (Only 2 of any projection allowed)

During practices the student may ask questions and/or receive help from the Clinical Instructor. competencies require the student to complete the exam with 100% accuracy with no help from the Clinical Instructor. ALL Practices and Competencies must be completed with direct supervision of the clinical instructor. ***All records of practices and competencies must be kept for at least 3 years.***

The Pediatric competencies must be completed to add the classification of "Pediatrics" to a Permit to Practice. This allows the Limited Radiographer to complete exams on those patients less than 36 months old.* ***During the education and training process students may count pediatric patients 6 years and under towards their practices and competencies.*

(1) All competency testing for limited radiography shall be directly supervised by the principal or clinical instructor.
(2) Clinical instructors shall directly supervise all students before the student's competency for a specific projection is documented and indirectly supervise after the student's competency for a specific projection is documented.
(3) Current permit holders completing formal education to add a category do not need to repeat the core curriculum.
42.31(3) Department approval is required before implementing any formal education or making any changes to a formal education offering.
42.31(4) Administrative items for all formal education:
a. The department reserves the right to audit or evaluate any aspect of the formal education or student progress.
b. The department may at any time require further documentation.

COMPLETION OF THIS COURSE OF STUDY SHOULD PREPARE THE STUDENT TO DEMONSTRATE COMPETENCY IN THE FOLLOWING AREAS:

- Radiation protection of patients and workers including monitoring, shielding, units of measurement and permissible levels, biological effects of radiation, and technical considerations in reducing radiation exposure and frequency of retakes;
- Technique and quality control to achieve diagnostic objectives with minimum patient exposure to include X–ray examination, X–ray production, image receptors, holders and grids, technique conversions, image processing, artifacts, image quality, and control of secondary radiation for the specified category;
- Patient care including, but not limited to, aseptic techniques, emergency procedures and first aid;
- Positioning, including normal and abnormal anatomy and projections for the specific category and verification of patient examinations;
- Radiographic equipment and operator maintenance to include X–ray tubes, grids, standardization of equipment, generators, preventive maintenance, basic electricity, and maintenance, collimators, X–ray control consoles, tilt tables, ancillary equipment, and electrical and mechanical safety;
- Special techniques limited to those required by the specific category; and
- Clinical experience sufficient to demonstrate competency in the application of the above as specified by the department.

ONCE THE TRAINING IS COMPLETED

Upon the completion of the training program, the following must be submitted to the agency:

1. A statement of competency from the principal or clinical instructor.
2. Completion certificate for the training program.
3. The application to take the certification exam.

Students DO NOT need to wait until the competencies are complete to take the exam. They won't receive their permit however until ALL competencies are completed.

Records of training MUST be retained for three years.

FINAL TESTING OF STUDENT

HHS contracts with the American Registry of Radiologic Technologists for the limited certification examination. Upon notification of training completion, the trainee should submit an application for testing. The student will receive a packet detailing the testing process and how to schedule the test. The test results will be sent to HHS and HHS will notify each trainee of the results. 70% is required to pass the test in each section.

REQUIRED FORMS

1. **Initial Clinical Site Form—**This form must be filled out by any clinical site/clinical instructor where the student may be completing Clinical Practices and/or Clinical Competencies. The completed form(s) is returned to the Principle Instructor who then forward them on to the HHS. **These forms must be reviewed and approved by the HHS before students can begin their Clinical Practices and/or Clinical Competencies.**
2. **Clinical Practice Record Sheet—**This form is used to keep track of the student's practices in each of the required areas. **This form does not need to be returned to the HHS but needs to be kept by the students for at least 3 years.** The example in this manual is only an example. Feel free to develop your own.
3. **Clinical Competency Record Sheet**—This form is used to keep track of the student's clinical competencies in each of the required areas. **This form does not need to be returned to the HHS but needs to be kept by the students for at least 3 years.** The example in this manual is only an example. Feel free to develop your own.
4. **Examination Evaluation Form for Final Competency**—The student should have one of these forms for **EACH** Clinical Competency they complete (pass or fail). **This form does not need to be returned to the HHS but needs to be kept by the students for at least 3 years.** The example in this manual is only an example. Feel free to develop your own.
5. **Clinical Competency Statement—**After a student has completed ALL Clinical Practices and Clinical Competencies then the Clinical Instructure will need to complete this form. **This form does need to be returned to the HHS.** If a student has utilized more than one Clinical Instructor (CI), then he or she will have the CI who completed the most number of exams fill out the form.
6. **Pediatric & Shoulder Competency Forms—**These forms are used for those Limited Radiographers who are going to add these classifications to an already existing Permit to Practice. **These Limited Radiographers would also need to use Forms 1—4 during their clinical education.**
7. **Application for Limited Radiography Examination—**Along with Clinical Competency Statement and a Certificate of Completion for the training program, send the completed application to the address provided at the end of the application. **The Application for Testing can also be completed, and it is suggested, online at** https://hhs.iowa.gov/permits-to-operate/limited-radiologic-technologist

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8. **Application for State of Iowa Limited Permit to Practice—**Once student has received the test results and have passed the Core section and at least one other section with at least a 70% and has completed the required clinical requirements they can then apply for Limited Permit to Practice. **This process can also be completed online and it suggested that one do so at http://HHS.iowa.gov/regulatory-programs/permits-to-practice.** If student applied to take their test online then they will not need to make a new account.

Forms 1, 5, & 6 are also available online at: https://hhs.iowa.gov/permits-to-operate/limited-radiologic-technologist

FORMS

Public Health
IOWA HHS

Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street, Des Moines, IA 50319

LIMITED RADIOGRAPHY INITIAL CLINICAL SITE FORM MUST BE SUBMITTED PRIOR TO STARTING CLINICAL EDUCATION

Trainee:_____(print name)

A principal instructor shall:
1. Be an Iowa-licensed chiropractor teaching spine and extremities categories only; or
2. Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or
3. Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

A clinical instructor shall:
1. Be an Iowa-licensed chiropractor teaching spine and extremities categories only; or
2. Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or
3. Be an Iowa-permitted limited radiologic technologist in the category of instruction and have at least two years of current experience in radiography; or
4. Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

Clinical instructors shall be supervised by the principal instructor. A principal instructor may also act as clinical instructor, if applicable. All competency testing for limited radiography shall be directly supervised by the principal or clinical instructor. Clinical instructors shall directly supervise all students before the student's competency for a specific projection is documented and indirectly supervise after the student's competency for a specific projection is documented. Classroom and clinical standards are listed in 641- 42.31(136C).

By signing below, you are agreeing that you meet these minimum requirements.

Site where clinical education will take place_____

_____

_____
Signature (Trainee) Date

_____
Principal Instructor name (printed)

_____
Signature Date

_____
Clinical Instructor name (printed)

_____
Signature Date

This form must be returned to the HHS for approval before Clinical Practices and/or Clinical Competencies can begin.

You may fax or email this form to: Matthew J. Millard, MSTD, RT(R)(CT) at 515-281-4529 or matthew.millard@idph.iowa.gov

Clinical Practice Record Sheet

Student _____

	Exam	Projection	Pt. Identification	Date	Evaluator
1	Chest (PA, AP, or Lateral)				
2	Chest (PA, AP, or Lateral)				
3	Chest (PA, AP, or Lateral)				
4	Chest (PA, AP, or Lateral)				
5	Chest (PA, AP, or Lateral)				
6	Chest (PA, AP, or Lateral)				
7	Chest (PA, AP, or Lateral)				
8	Chest (PA, AP, or Lateral)				
9	Chest (PA, AP, or Lateral)				
10	Chest (PA, AP, or Lateral)				
11	Chest (PA, AP, or Lateral)				
12	Chest (PA, AP, or Lateral)				
13	Chest (PA, AP, or Lateral)				
14	Chest (PA, AP, or Lateral)				
15	Chest (PA, AP, or Lateral)				
16	Chest (PA, AP, or Lateral)				
17	Chest (PA, AP, or Lateral)				
18	Chest (PA, AP, or Lateral)				
19	Chest (PA, AP, or Lateral)				
20	Chest (PA, AP, or Lateral)				
21	Chest (PA, AP, or Lateral)				
22	Chest (PA, AP, or Lateral)				
23	Chest (PA, AP, or Lateral)				
24	Chest (PA, AP, or Lateral)				
25	Chest (PA, AP, or Lateral)				
26	Chest (PA, AP, or Lateral)				
27	Chest (PA, AP, or Lateral)				
28	Chest (PA, AP, or Lateral)				
29	Chest (PA, AP, or Lateral)				
30	Chest (PA, AP, or Lateral)				

Clinical Competency Record Sheet

Student _____

	Exam	Projection	Patient ID	Date	Evaluator
1	PA/AP Chest				
2	PA/AP Chest				
3	PA/AP Chest				
4	PA/AP Chest				
5	PA/AP Chest				
1	Lateral Chest				
2	Lateral Chest				
3	Lateral Chest				
4	Lateral Chest				
5	Lateral Chest				
1	Upper Extremity				
2	Upper Extremity				
3	Upper Extremity				
4	Upper Extremity				
5	Upper Extremity				
6	Upper Extremity				
7	Upper Extremity				
8	Upper Extremity				
9	Upper Extremity				
10	Upper Extremity				
1	Lower Extremity				
2	Lower Extremity				
3	Lower Extremity				
4	Lower Extremity				
5	Lower Extremity				
6	Lower Extremity				
7	Lower Extremity				
8	Lower Extremity				
9	Lower Extremity				
10	Lower Extremity				

EXAMINATION EVALUATION FORM FOR FINAL COMPETENCY

Student name_____ Type of Examination_____

Performance Objective: Given a patient and the necessary equipment, the student will demonstrate the ability to:

Examination Preparation

- cassettes, holding devices, etc. available	☐ Yes	☐ No
- laundry stocked in the room and the bathroom	☐ Yes	☐ No
- room and table ready for patient	☐ Yes	☐ No
- necessary supplies available	☐ Yes	☐ No
- equipment set properly	☐ Yes	☐ No
- emergency equipment available for use if necessary	☐ Yes	☐ No

Examination Performance

- patient dressed properly for exam	☐ Yes	☐ No
- checks orders	☐ Yes	☐ No
- explains procedure to patient	☐ Yes	☐ No
- assists patient onto table or examination area	☐ Yes	☐ No
- takes patient history and records it for physician	☐ Yes	☐ No
- gives clear and concise patient instructions	☐ Yes	☐ No
- positions equipment and patient properly	☐ Yes	☐ No
- makes exposure properly	☐ Yes	☐ No
- watches patient closely	☐ Yes	☐ No
- works with speed and efficiency	☐ Yes	☐ No
- is aware of and practices good radiation protection habits	☐ Yes	☐ No

Exam Completion

- critiques final examination	☐ Yes	☐ No
- checks study with Physician as necessary	☐ Yes	☐ No
- produces diagnostic study	☐ Yes	☐ No
- places completed exam in proper area	☐ Yes	☐ No
- returns patient to indicated area (their room, ER, OPT, etc.)	☐ Yes	☐ No
- replaces supplies as necessary	☐ Yes	☐ No
- maintains a clean and neat working area	☐ Yes	☐ No
- makes sure all information is correctly recorded	☐ Yes	☐ No

COMMENTS_____

_____

The evaluator's signature verifies that the procedure was completed satisfactorily.

Signature: _____ Date:_____

Public Health
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Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street, Des Moines, IA 50319

COMPLETION OF RADIOGRAPHY CLINICAL TRAINING AND STATEMENT OF COMPETENCY

Trainee: _____

As clinical instructor for the above individual, I verify that this individual has:

1. Demonstrated good patient care.
2. Demonstrated appropriate radiation protection for self, staff, and patient.
3. A clinical program that included:
    a. Equipment maintenance, exposures and positioning, image processing, image evaluation for quality (*Check the following applicable categories*):
        [ ] Competency in PA and Lateral chest procedures
        [ ] Competency in upper extremities procedures
        [ ] Competency in lower extremities procedures
        [ ] Competency in spinal procedures
        [ ] Competency in shoulder procedures
        [ ] Competency in additional pediatric procedures
4. Direct supervision by me for all practices and competencies
5. Has satisfactorily completed the required competencies with 100% accuracy.

I verify that the above individual is competent to perform radiography in the above checked areas according to the Bureau of Radiological Health's requirements. I have records of the clinical competencies on file at my facility for review. I grant permission for a representative of HHS to comprehensively evaluate whether the above individual meets the HHS training standards

_____ _____
Name of Clinical Instructor (signed) Date

_____
Name of Clinical Instructor (printed)

_____
Address

_____
Phone

_____
Email

You may fax or email this form to: Matthew J. Millard, MSTD, RT(R)(CT) at 515-281-4529 or matthew.millard@idph.iowa.gov

Public Health
IOWA HHS

Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street, Des Moines, IA 50319

COMPLETION OF RADIOGRAPHY TRAINING FOR PEDIATRICS AND STATEMENT OF COMPETENCY

Trainee: _____

As the instructor for the above individual, I verify that this individual has completed:

1. Classroom training in pediatric anatomy and radiation protection; and
2. A clinical program that included:
    a. Positioning, image critique, and competency testing for either chest or extremities, or both, and
    b. Direct supervision by me

I verify that the above individual is competent to perform limited radiography according to the Bureau of Radiological Health's requirements for the following categories:

[ ] pediatric chest [ ] pediatric extremities

I grant permission for a representative of HHS to comprehensively evaluate whether the above individual meets the HHS training standards.

_____ _____
Name of Clinical Instructor (signed) Date

_____
Name of Clinical Instructor (printed)

_____
Address

_____
Phone

You may fax or email this form to: Matthew J. Millard, MSTD, RT(R)(CT) at 515-281-4529 or matthew.millard@idph.iowa.gov

Public Health
IOWA HHS

Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street, Des Moines, IA 50319

COMPLETION OF SHOULDER RADIOGRAPHY TRAINING AND STATEMENT OF COMPETENCY

Trainee: _____

As the instructor for the above individual, I verify that this individual has completed:

1. Classroom training in pediatric anatomy and radiation protection; and
2. A clinical program that included:
    a. Positioning, image critique, and competency testing for AP internal and external rotation, AP neu tral, and transthoracic lateral procedures and
    b. Direct supervision by me

I verify that the above individual is competent to perform limited radiography according to the Bureau of Radiological Health's requirements for the following categories:

I grant permission for a representative of HHS to comprehensively evaluate whether the above individual meets the HHS training standards.

_____ _____
Name of Clinical Instructor (signed) Date

_____
Name of Clinical Instructor (printed)

_____
Address

_____
Phone

You may fax or email this form to: Matthew J. Millard, MSTD, RT(R)(CT) at 515-281-4529 or

matthew.millard@idph.iowa.gov

IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES, BUREAU OF RADIOLOGICAL HEALTH

APPLICATION FOR LIMITED RADIOGRAPHY EXAMINATION

INSTRUCTIONS FOR COMPLETING THIS FORM:

Print or type the required information. Send the completed form to: Iowa Department of Health and Human Services, Bureau of Radiological Health Lucas State Office Building, 5th Floor, 321 East 12th Street, Des Moines, IA 50319

All exam fees will be paid directly to the ARRT, the provider of the exam. A letter will be sent to the applicant once verification has been made explaining the payment process.

If you have any questions, please contact:

Questions: 855-824-4357 Email: ADPEREHreg@idph.iowa.gov

APPLICANT'S INFORMATION:

First Name: _____

Middle Name: _____

Last Name: _____

Street Address: _____

City: _____ State:_____ Zip: _____

Phone Number: _____ Date of Birth: _____

Email: _____ SSN Number: _____

Check all that apply: The core module must be passed in addition to at least one other module before a permit can be issued. **Do not sign up again for any modules you have already passed.**

- ☐ **Core**: *radiation protection, equipment operation and quality control, image production evaluation, patient care and education*
- ☐ **Chest procedures**
- ☐ **Extremities procedures**
- ☐ **Spinal procedures**

Training School: _____

Do you have a medical condition, which in any way currently impairs or limits your ability to perform the duties of this profession? Medical Condition: means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.
If yes, provide a description of your condition and submit a letter from a physician stating how your condition will affect your ability to perform the duties of this profession.

☐ Yes ☐ No

Have you, within the past 5 years, engaged in the illegal or improper use of drugsor other chemical substances?
If yes, provide a statement and a copy of relevant documentation including recordsfrom a physician or treatment program.

☐ Yes ☐ No

Have you ever been convicted of a misdemeanor or felony crime? (You do not need to answer yes if your sole conviction or convictions are for minor traffic violations with fines under $250). In answering this question, note that a conviction means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. This means you must answer yes if a finding or verdict of guilt was returned against you in a criminal proceeding or if you plead guilty, entered a plea of nolo contendere, or entered an Alford plea in a criminal proceeding, even if the court expunged the matter or the court deferred judgment. You must submit the complaint and judgment of conviction for each offense.
If yes, include the date, location, charging orders, court disposition, and current status (i.e. probation) for each charge.

☐ Yes ☐ No

Has any state or other jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or otherwise disciplined a professional license, permit, registration, or certification issued to you?
If yes, include the date, location, reason, and resolution.

☐ Yes ☐ No

Have there ever been judgments or settlements paid on your behalf as a result of aprofessional liability case?
If yes, include the date, location, reason, and resolution.

☐ Yes ☐ No

Have you ever had a license, permit, registration, or certification denied,suspended, revoked, or otherwise disciplined by a certification body?
If yes, provide a description of the circumstances.

☐ Yes ☐ No

Please provide responses to "Yes" questions on a separate piece of paper(s).

EMPLOYER INFORMATION: (Use additional pages for employer information if necessary.)

Contact Type: Current Employer No Employer Previous Employer

First Name: _____ Last Name: _____

Phone Number: _____ Email Address: _____

License Number: _____ Business Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Comments: _____

Contact Type: Current Employer No Employer Previous Employer

First Name: _____ Last Name: _____

Phone Number: _____ Email Address: _____

License Number: _____ Business Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Comments: _____

OUT OF STATE LICENSES:

If you have a current, expired, or inactive permit or license in another state, please list the details below:

State of Issuance: _____ Type of License: _____

License Number: _____ License Expiration Date: _____

Privacy Act Notice: Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning my application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that I am required to update answers or information submitted herewith if the response or the information changes.

In submitting this application, I consent to any reasonable inquiry that may be necessary to verify or clarify the information I provided on or in conjunction with this application.

I understand that this information is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.

I have read the Administrative Rules governing this profession and I agree to comply with those provisions.

_____ _____

SIGNATURE OF APPLICANT DATE

Ensure that all documentation of proof of completion of the didactic and clinical education is included.

Application and required documentation should be sent to:

HHS, Bureau of Radiological Health

Lucas State Office Building, 5th Floor

321 East 12th Street

Des Moines, IA 50319

Iowa Department of Health and Human Services, Bureau of Radiological Health

Application for State of Iowa Limited Permit to Practice

*Before submitting this application you are **required** to pass the ARRT Limited Certification Examination.*

Mailing Address:

HHS
Bureau of Radiological Health
Lucas State Office Building, 5th Floor 321 East 12th Street
Des Moines, IA 50319

Send the following to the Mailing Address given:

- Your completed application.
- A ***nonrefundable fee*** in a check or money order pay able to: **Iowa Department of Health & Human Services.**
- Your Classroom and Clinical Education Completion Documentation. ***(New Applications Only.)***
- Your transcript of CEU hours (if due.)

Questions?

Customer Support Phone: 855-824-4357 Email: adperehreg@idph.iowa.gov

Internet Address: https://hhs.iowa.gov/permits-to-operate/limited-radiologic-technologist

APPLICANT'S INFORMATION: *(Type or print the information below.)* ☐ This is a new address

First Name: _____ Middle Name:

Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: ___

Phone Number: _____ Date of Birth: _____

Email: _____ SSN: _____

Have you held an Iowa Permit to Practice before? Y ☐ N ☐ Permit Number RAD _____

Reinstatement - If you allow your permit to expire you will be required to apply for reinstatement, meaning you will need to pay the $60 fee that would be charged for a new permit. You will also be subject to investigation for working without a permit.

Select Limited Permit Type(s): Your renewal application should be submitted approximately **45 days before** your permit expires.

☐ Chest ☐ Extremities ☐ Spines ☐ Shoulder ☐ Pediatrics

Select Application Type:

☐New $100 ☐Reinstatement $150 ☐Renewal $75

To Add a Type:

If you elect to add a type to an existing permit be sure to include a **nonrefundable $40** amendment fee with this application. **Ensure that you include proper documentation of didactic & clinical training.**

☐ Add Chest ☐ Add Extremities ☐ Add Spines ☐ Add Shoulder ☐ Add Pediatrics

Do you have a medical condition, which in any way currently impairs or limits your ability to perform the duties of this profession? Medical Condition: means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.
If yes, provide a description of your condition and submit a letter from a physician stating how your condition will affect your ability to perform the duties of this profession.

☐ Yes ☐ No

Have you, within the past 5 years, engaged in the illegal or improper use of drugsor other chemical substances?
If yes, provide a statement and a copy of relevant documentation including recordsfrom a physician or treatment program.

☐ Yes ☐ No

Have you ever been convicted of a misdemeanor or felony crime? (You do not need to answer yes if your sole conviction or convictions are for minor traffic violations with fines under $250). In answering this question, note that a conviction means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. This means you must answer yes if a finding or verdict of guilt was returned against you in a criminal proceeding or if you plead guilty, entered a plea of nolo contendere, or entered an Alford plea in a criminal proceeding, even if the court expunged the matter or the court deferred judgment. You must submit the complaint and judgment of conviction for each offense.
If yes, include the date, location, charging orders, court disposition, and current status (i.e. probation) for each charge.

☐ Yes ☐ No

Has any state or other jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or otherwise disciplined a professional license, permit, registration, or certification issued to you?
If yes, include the date, location, reason, and resolution.

☐ Yes ☐ No

Have there ever been judgments or settlements paid on your behalf as a result of aprofessional liability case?
If yes, include the date, location, reason, and resolution.

☐ Yes ☐ No

Have you ever had a license, permit, registration, or certification denied,suspended, revoked, or otherwise disciplined by a certification body?
If yes, provide a description of the circumstances.

☐ Yes ☐ No

Please provide responses to "Yes" questions on a separate piece of paper(s).

EMPLOYER INFORMATION: (leave blank if No Employer)

Current Employer

Supervisor's Name: _____

Phone Number: _____ Email Address: _____

Business Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Previous Employer (if current employer is less than 1 year)

Supervisor's Name: _____

Phone Number: _____ Email Address: _____

Business Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I am submitting CEU's**

12 hours of continuing education is required at the end of your Biennium Date. Include a copy of your transcript showing all courses completed if this is the year you are required to report hours. If the educational organization you are working with does not have a transcript, please send copies of your certificates of completion.

Privacy Act Notice: Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a) (13) and Iowa Code § 252J.8 (1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning my application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that I am required to update answers or information submitted herewith if the response or the information changes.

In submitting this application, I consent to any reasonable inquiry that may be necessary to verify or clarify the information I provided on or in conjunction with this application.

I understand that this information is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.

I have read the Administrative Rules governing this profession and I agree to comply with those provisions.

_____ _____

Signature of Applicant **(REQUIRED)** Date