

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH**

Radiographer Licensure  
Email: [dph.alliedhealth@ct.gov](mailto:dph.alliedhealth@ct.gov)  
Website: [www.ct.gov/dph/license](http://www.ct.gov/dph/license)

**Radiographer License Application**

**Tape a recent photo  
of applicant here.  
DO NOT STAPLE**

This application must be accompanied by a check or money order in the amount of **\$200.00**, made payable to **"Treasurer, State of Connecticut."**

➔ **Return completed application and fee to:**

**CT DPH, Radiographer Application Processing, 410 Capitol Ave., MS# 12MQA, PO Box 340308, Hartford, CT 06134**

First Name		MI	Last Name		Maiden Name	Social Security Number	
Email Address			Street Address		City	State	Postal Code
Telephone Number		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		Ethnicity: check (✓) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
Race: Please check (✓) all that apply <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White							
Have you held a Connecticut radiographer license in the past?						<input type="checkbox"/> Yes <input type="checkbox"/> No	Lic. No.
Are you now or have you ever been licensed as a radiographer in any state? If yes, please list all (please abbreviate): _____							<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Radiographer School				City		State	Degree Date
Have you successfully completed the certification examination administered by the American Registry of Radiologic Technologists (ARRT)?					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Radiography <input type="checkbox"/> Radiation Therapy	Exam Date
Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: Any hospital, nursing home, clinic, or similar institution; Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public; Any professional school, clinical clerkship, internship, externship, preceptorship; or postgraduate training program; Any third party reimbursement program, whether governmental or private?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?							<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state?							<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If you answered yes to any of the above questions regarding your professional history, please provide full details and provide supporting documentation (e.g. certified court copy with court seal affixed, complaint, answer, judgment, settlement or disposition) that will assist this office's review.</b>							
NOTARIZATION: On this _____ day of _____, 20____, the above referenced individual personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein or any document attached hereto are true in every respect.							
Sworn to before me this ____ day of _____, 20_____.							
_____ Signature of Applicant			_____ Signature of Notary Public			My Commission Expires: _____	