

Please read entire content as it pertains to changes in [Part 401](#) in regards the limited scope examination fee increase and payment.

From time to time, as ARRT's cost of doing business increases, it becomes necessary to adjust examination fees. The Limited Scope of Practice in Radiography exam has increased from \$125 to \$140 as of January 1, 2020.

**ARRT is now accepting payment by credit card. Instructions will be sent upon acceptance and processing of application.**

The completed and signed application can be sent by email to [ema.radtech@illinois.gov](mailto:ema.radtech@illinois.gov) or faxed 217-785-9946. Once the application is received and processed an email will be sent with a link on how to pay the \$140 fee (there currently is no convenience fee). You will not need to mail us anything.



# ILLINOIS EMERGENCY MANAGEMENT AGENCY

## Application for Examination in Limited Radiography

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1. The application must be complete, signed and legible. Print or type all information.
2. The **\$140 fee** is payable to ARRT by credit card. Payment instructions will be emailed after processing application. Application fees are non-refundable.
3. Please email (ema.radtech@illinois.gov) or fax (217-785-9946) the completed application.
4. If you have any questions, please call 217-785-9913.

Social Security Number: _____ <small style="text-align: center;">(###-##-###)</small>	Birthdate: _____ <small style="text-align: center;">(mm/dd/yyyy)</small>
Name: _____ <small style="text-align: center;">Last                      First                      MI</small>	Business Telephone: _____
Address: _____ <small style="text-align: center;">Number and Street</small>	Home/Cell Telephone: _____
_____ <small style="text-align: center;">City                      State                      Zip</small>	Email (Required): _____ <small style="text-align: right;"><i>Grades will be sent electronically</i></small>

Application for:      Exam      Re-exam

Check the appropriate categories for which you wish to be examined:      Chest      Spine      Extremities      Skull and Sinuses

Month and year you wish to be examined: \_\_\_\_\_  
 Please allow approximately 3 weeks for scheduling exam.      (mm/yyyy)

### SUPERVISION ATTESTATION

**Personal (in the room) supervision of the trainee is required during a radiographic procedure. As such, only a licensed physician or Agency accredited radiographer may initialize the x-ray exposure.**

Physican Acknowledgment:

_____	_____	_____
Printed Name	Signature	Date

### EMPLOYER INFORMATION

Facility Registration #: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address / City / Zip: \_\_\_\_\_

_____	_____
Applicant Signature	Date Application Signed