



Radiation Control, X-ray Unit
 625 Robert Street North
 P.O. Box 64975
 St. Paul, Minnesota 55164-0975
 Phone: 651-201-4545
www.health.state.mn.us/xray

Limited Scope X-ray Operator Application

A. Applicant Information

Name (as it appears on your social security card)

First Middle Initial Last

Home Address: _____ City/State/Zip: _____

Date of Birth: _____ (XX/XX/XXXX) Social Security Number: _____ - _____ - _____

Phone #: _____ Email: _____

Training/Courses completed in preparation for this exam: _____

B. Testing (Limited Scope Exam and modules cannot be taken at the same time as the Bone Density Exam)

Limited Scope Core Exam
At least one module MUST be taken. Applicant can only take x-rays on exams passed.

Check which modules you are taking along with the Limited Scope Exam:

Chest Extremity Podiatry SkullSinus Spine

Bone Density Core Exam

Retake Exam (Please check which exams/modules you are retaking or adding)

Limited Scope Core Chest Extremity Podiatry Skull/Sinus Spine

Bone Density Core

C. Fees Due

\$100.00 Certified Check or Money Order (ARRT fees, MDH will forward to ARRT)
 \$ 25.00 Certified Check or Money Order (MDH Processing Fee)

Both fees must be mailed to MDH, must be separate certified check or money orders, and are NONREFUNDABLE. We strongly recommend sending money through the mail as Certified Mail. Combining fees into one payment will delay processing by 60 days. We will not accept personal checks for fees. Your \$100.00 fee will be forwarded to ARRT.

D. Signature

I declare that all the information I have provided is true and complete, and that I have read and understand the attached "Tennessee Warning". We are requesting your name, address and phone number so that we may contact you for further information relating to your Limited X-ray Operator registration. You are not required to provide this information. However, without it we will not be able to contact you regarding additional information that may be needed. All information you provide is legally classified as confidential data for individuals and can only be released to Minnesota Department of Health employees as need to process renewal registration, and anyone having a court order to obtain the information.

Applicant Signature _____ Date _____

Before mailing, be sure to:

- Fill out all sections of the application, sign and date
- Submit \$100.00 **certified check or money order** payable to ARRT
- Submit \$25.00 **certified check or money order** payable to MDH
- Submit application and fees as Certified Mail

MAIL ALL TO: Minnesota Department of Health
 Radiation Control, X-ray Unit
 625 Robert Street North
 PO Box 64497
 St. Paul, MN 55164-0497



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St. Paul, MN 55164-0975
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Notice given with x-ray operator application.