

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dspd@wisconsin.gov
Website: <http://dspd.wi.gov>

RADIOGRAPHY EXAMINING BOARD

INFORMATION FOR COMPLETING LIMITED X-RAY MACHINE OPERATOR (LXMO) PERMIT APPLICATION

INSTRUCTIONS FOR LICENSURE:

Applicant must:

- Be at least 18 years of age.
- Per Wis. Stat. §[462.03\(1\)\(b\)](#), hold a high school diploma or its equivalent, as determined by the Board.
- Per Wis. Stat. §[462.03\(1\)\(c\)](#), subject to Wis. Stat. §§ [111.321](#), [111.322](#), and [111.335](#), the person does not have an arrest or conviction record.
- **Submit the following:**
 - Application Form (#2903):** Complete the application and attach the appropriate fee. Make check payable to "Department of Safety and Professional Services." Your canceled check will be your receipt. Mail to the Department of Safety and Professional Services at the address listed below.
 - Program Curriculum Form (#2990):** This form must be forwarded and completed by your school and returned directly to the Department of Safety and Professional Services.
 - Verification of Licensure (if applicable):** You are required to have each state or territories of the United States you are or have been credentialed in submit a letter of verification to the Wisconsin Radiography Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and statement regarding disciplinary actions.
 - Wisconsin Limited Scope Examination:** After you receive authorization to sit for the Wisconsin Limited Scope Examination, you will receive further notification from the Department to register online at www.arrt.org and pay the appropriate examination fee directly to ARRT. For further information concerning the ARRT exam, please visit the following link: <https://www.arrt.org/Examination>.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for Department mail. A change of address must be reported to the Department within 30 days.

MAILING INSTRUCTIONS

Mail the application, the appropriate fee, and supporting documentation to the following address:

DSPS
ATTN: Radiography Examining Board
P.O. BOX 8935
MADISON, WI 53708-8935

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
 Madison, WI 53708-8935
 FAX #: (608) 251-3036
 Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
 Madison, WI 53705
 E-Mail: dsps@wisconsin.gov
 Website: <http://dsps.wi.gov>

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LIMITED X-RAY MACHINE OPERATOR (LXMO) PERMIT APPLICATION

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK Your name, address, telephone number and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address (street, city, state, zip)	Daytime Telephone Number
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

Mailing Address (if different)	Date of Birth
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Social Security Number	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
<input type="text"/> - <input type="text"/> - <input type="text"/>	

Ethnicity/gender status information is optional.

Ethnicity: White, not of Hispanic origin American Indian or Alaskan Hispanic
 Black, not of Hispanic origin Asian or Pacific Islander Other

Sex: M F

Have you ever been licensed in Wisconsin as a LXMO? Yes No If yes, list your credential number:

Email Address

School Name	School Address (street, city, state)
<input type="text"/>	<input type="text"/>
Date Degree Granted	Degree
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

I am seeking a Veteran Fee Waiver (for Initial Credential Fee only, see page 2 for further information)

Initial Credential
 \$65.00 Initial Credential Fee
 \$15.00 ARRT Contract Exam Fee
\$80.00 Total Fee Attached

I will be taking one or more of the following examinations: (choose which exam(s) you are applying for)

*ARRT Chest (thorax, lungs, ribs)
 *ARRT Extremities (upper and lower extremities, including pectoral girdle but excluding hip and pelvis)
 *ARRT Podiatry (foot, ankle, and lower leg below the knee)
 *ARRT Spine (cervical, thoracic, and lumbar)
 WI license expired (5) five years or more
 \$ 65.00 Renewal Fee
 \$ 25.00 Late Fee
\$ 90.00 Total Fees Attached

For Receiving Use Only (144)

Wisconsin Department of Safety and Professional Services

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Application (Form #2903) and appropriate fee <input type="checkbox"/> Program Curriculum Form (#2990) <input type="checkbox"/> Letters from all State Boards where licensed, active and inactive <input type="checkbox"/> Convictions and Pending Charges (Form #2252), if applicable <input type="checkbox"/> ARRT Ethics Review Letter, If applicable | <ul style="list-style-type: none"> <input type="checkbox"/> Malpractice Suits or Claims (Form #2829) and copies of malpractice suit, court documents with allegations and settlement, if applicable <input type="checkbox"/> Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc. |
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ARE YOU A VETERAN? If yes, please view the Department website at <https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx> for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? Yes No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number:

If you qualify, are you requesting equivalency of your Military Training and experience? Yes No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? Yes No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

You may contact the DVA at 1-800-WisVets or www.WISVETS.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at <http://dsps.wi.gov> and select "Professions," then "Limited X-Ray Machine Operator Permit."

RADIOGRAPHY COURSE OF STUDY: (Attach additional sheets, if necessary.)

Institution/School	Location of School (City/State)	Dates Attended (Month/Year)	Degree
	(City) <input style="width: 150px; height: 20px;" type="text"/> (State) <input style="width: 40px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
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I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S). (Include all active and inactive states.)

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For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Radiography Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

REGARDING THE STATES YOU LISTED ABOVE: Identify the states in which you were licensed by EXAM.

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ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

1.	Have you ever been convicted of a misdemeanor or a felony, or do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been terminated from any employment related to the practice of radiography? If yes, please explain below: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a limited x-ray machine operator with reasonable skill and safety" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned radiography judgments and to learn and keep abreast of radiography developments; and
2. The ability to communicate those judgments and radiography information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform LXMO tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

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ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

7.	Do you have a medical condition, which in any way impairs or limits your ability to practice as a LXMO with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice as a LXMO with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION OF LEGAL STATUS

I declare under penalty of law that I am (check one):

- A citizen or national of the United States, or
- A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: _____ Date: / /