Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

RADIOGRAPHY EXAMINING BOARD

LIMITED X-RAY MACHINE OPERATOR LIMITED SCOPE EXAM AND RETAKE REQUEST

(Request to take additional exams, or re-write failed exams.)

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 street address/PO Box, phone number and email address are available to the public. Check box to withhold street address/PO Box, phone 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)**

Address (number/street, city, state, zip code)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

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.

Ethnicity/gender status information is optional.

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

Sex: ☐ M ☐ F

Email Address

Please check all that applies:

☐ I have a Limited X-Ray Machine Operator permit and want to take additional exam(s) to expand the scope of my permit. WI LXMO Permit Number:

☐ I have failed the Wisconsin Limited Scope exam and wish to retest.

School Name

School Address (street, city, state)

Date Degree Granted __ / __ / ____

Degree

APPLICATION FEES:

☐ ARRT Contract Exam Fee
$15.00 Total Fee Attached

Choose which limited scope exam(s) you are applying for or requesting to retake:

☐ ****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)

*Each examination designates the limited scope of practice of an X-Ray Machine Operator.

**Once you receive DSPS authorization to sit for the exam, you will receive further notification from DSPS to register online at www.arrt.org and pay the appropriate limited scope exam fee directly to ARRT.

For Receipting Use Only (144)

Wisconsin Department of Safety and Professional Services

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

Application (**Form #2938**) and appropriate fee

LIMITED SCOPE EXAMINATION:

Have you taken and passed the Wisconsin Limited Scope examination? ☐ Yes ☐ No

If yes, list examinations already taken:

List examinations you are applying for:

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 have provided to the Department of Safety and Professional Services change.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

(If unable to provide a digital signature print and sign form.)