



THE SOUTH CAROLINA RADIATION QUALITY STANDARDS ASSOCIATION

P.O. Box 7515 • Columbia, SC 29202 • Telephone # (877) 771-6141 • Fax # (803) 771-8048 • www.scrqsa.org

APPLICATION FOR RECERTIFICATION

****Individuals qualifying as ARRT, NMTCB, ISCD, PET, CT or RCIS certified must include a copy of the current ARRT, NMTCB, ISCD or RCIS certification card. We do not need copies of your CEs as long as you are in good standing. [This only applies to the certifications in the LEFT column below]**

***Individuals applying for recertification that hold a limited certificate must provide copy of the appropriate number of hours of continuing education documentation. [This only applies to of the certifications in th Right column below].**

The CERTIFICATON FEE IS \$50.00 for two-year certification cycle (regardless of the number of categories checked). Please make checks payable to the SCRQSA. This fee is NOT refundable. A LATE FEE OF \$10 WILL BE CHARGED IF RENEWAL IS MORE THAN THIRTY DAYS LATE. Payment of fee is not deductible as charitable contribution but may qualify as an employee business expense deduction on your personal tax return. Your application must be signed and dated or it will be returned. Expedited application require and additional \$25 processing fee.

IMPORTANT NOTICE: Failure to provide complete and accurate information in each of the spaces provided or failure to include the correct fee will result in an incomplete application. Incomplete applications are returned and penalties will be applied. It is your responsibility to notify the SCRQSA office within 30 days of a change of address and/or name change in writing.

CERTIFICATIONS OFFERED

- | | |
|--|--|
| <input type="checkbox"/> Radiography (ARRT)** | <input type="checkbox"/> Limited Practice Radiographer-General* (12 hours CE) |
| <input type="checkbox"/> Radiography (Non-ARRT)* (24 hours CE) | <input type="checkbox"/> Limited Practice Radiographer-Chest* (6 hours CE) |
| <input type="checkbox"/> Nuclear Medicine Technology (ARRT or NMTCB)** | <input type="checkbox"/> Limited Practice Radiographer-Podiatric* (6 hours CE) |
| <input type="checkbox"/> Radiation Therapist (ARRT)** | <input type="checkbox"/> Limited Practice Radiographer-Chiropractic* (12 hours CE) |
| <input type="checkbox"/> Radiation Therapist (Non-ARRT)* (24 hours CE) | <input type="checkbox"/> Bone Densitometry Operator (ISCD)* (12 hours CE) |
| <input type="checkbox"/> Invasive Specialist (ARRT, RCIS)** | <input type="checkbox"/> Bone Densitometry Operator* (12 hours CE) |
| <input type="checkbox"/> PET (NMTCB)** | <input type="checkbox"/> Limited Bone Densitometry Operator- Peripheral |
| <input type="checkbox"/> Computed Tomography/CT (ARRT)** | |
| <input type="checkbox"/> Computed Tomography/CT – Non-Diagnostic (NMTBC)** | |

Please PRINT clearly or TYPE

Last Name _____ First Name _____ M.I. _____

Home Mailing

Address: _____ Check here if new address and/or name change
change

City _____ State _____ Zip Code _____

Home Phone Number _____ SCRQSA Certificate # _____

Birthdate and Social Security must be provided for purposes of positive identification.

MO DAY YR XXX - XX - _____ E-MAIL: _____
SOCIAL SECURITY # (last 4 digits) [please supply an E-mail that you check regularly]

EMPLOYMENT FACILITY

Check if more than one place of employment Check here if wish to be excluded from the online directory of certificate holders

Signature of applicant (not valid without a Signature)

Date of Application

For Credit Card Payments: Please check credit card type: _____ MasterCard _____ VISA _____ DISCOVER

Card Number: _____ Expiration Date: _____ CVV Code: _____

Signature of Card Holder: _____ Billing Zip Code: _____

FOR OFFICE USE ONLY: _____ Check/Money Order Number _____ Credit Card _____ Amount Paid _____ v. January 2020