Iowa Department of Public Health

Radiologic Technologist Requalification Worksheet

Please submit supporting documentation

___Iowa Permit to Practice # _____

___General Certification - ARRT or ARCRT

___Documentation of 40 hour training (any (1) of the folllowing)
__ARRT(M) (can't use if date is 4/28/99 to 1/1/01)
__In house Program
__Other approved program
Name_____

___25 supervised patients

___15 mammography specific CEU's

For State of Iowa use

REQUALIFICATION DATE_____

INITIAL QUALIFICATION START DATE_____
(10/01/94 or date initial qualification was completed)

ADDITIONAL MODALITY START DATE_____
(8 hours initial training in each additional mammographic modality)

NAME OF TECHNOLOGIST_____

PLACE OF EMPLOYMENT_____

LOCATION OF TRAINING_____

NAME OF TRAINER_____ **PP#** _____

IDPH Approval _____

Date _____