

SPECIAL RENEWAL APPLICATION*

* This form is for use **only** by those who did not receive their renewal billing notice 45 days before their expiration date.

For X-Ray Technician Bone Densitometry Limited Permit

| | | | |
|--|------------------------|---------------------------|----------|
| Number (shown on your Permit) | Expiration Date | This box for RHB use only | |
| Last Name, suffix | First Name | Middle Name | |
| Date of Birth | Social Security Number | Phone Number | |
| Mailing Address <input type="checkbox"/> Check this box if your address has changed since your last permit was issued. | | | |
| City | | State | ZIP Code |

It is very important that you provide your full true name.

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. For information or access to your records, contact the Chief of the Certification Unit at the California Department of Public Health, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

Return this form with your applicable nonrefundable renewal fee payment in the form of a check or money order payable to **“CDPH-RHB”** (California Department of Public Health – Radiologic Health Branch):

- \$70.00** if your permit has not expired.
- \$81.08** if your permit expired within the past six months.
- \$151.08** if your permit expired within the past 5½ years.

Note: Permits can not be renewed after 5½ years from the expiration date, you will need to reapply.

REQUEST FOR CANCELLATION

I do not wish to renew one or all of my certificate(s) or permit(s). Cancel the following certificate or permit: _____

You are required to earn 24 hours of approved continuing education credits within the past two years. Complete extra copies of page 2 of this form if needed to list the required approved continuing education credits you have earned and return them along with this page and payment to:

**Billing and Cashiering Unit
California Department of Public Health
Radiologic Health Branch, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414**

I certify that all information provided with this application is true and correct. I understand that the California Department of Public Health may cancel permits that are procured by fraud, misrepresentation, or mistake, and may revoke permits for the nonpayment of fees. Further, I am aware that it is unlawful to use X-rays on human beings in this state unless I am permitted pursuant to the Radiologic Technology Act, I am acting within the scope of that permit, and I am acting under the supervision of a licentiate of the healing arts who is a certified supervisor or operator.

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

Earned Approved Continuing Education Credits for Renewing California X-Ray Technician Bone Densitometry Limited Permit

This list can only be accepted when submitted with a completed RENEWAL APPLICATION form and fees.

| | | |
|-------------------------------|-----------------|---------------------------|
| Number (shown on your Permit) | Expiration Date | This box for RHB use only |
|-------------------------------|-----------------|---------------------------|

An approved continuing education credit is one hour of instruction received in subjects related to the application of X-ray to the human body and accepted for purposes of credentialing, assigning professional status, or certification, by any of the following **groups**:

- | Code | Group |
|-----------|--|
| A. | American Registry of Radiologic Technologists; |
| B. | Medical Board of California; |
| C. | Osteopathic Medical Board of California; |
| D. | Board of Podiatric Medicine; |
| E. | California Board of Chiropractic Examiners; |
| F. | Board of Dental Examiners. |

| | | | | |
|---------------------|------------------------|------|------|-------|
| Course Title | | | | |
| Provider or Sponsor | Location (City, State) | Date | Code | Hours |
| Course Title | | | | |
| Provider or Sponsor | Location (City, State) | Date | Code | Hours |
| Course Title | | | | |
| Provider or Sponsor | Location (City, State) | Date | Code | Hours |
| Course Title | | | | |
| Provider or Sponsor | Location (City, State) | Date | Code | Hours |
| Course Title | | | | |
| Provider or Sponsor | Location (City, State) | Date | Code | Hours |

Do not send us copies of your Continuing Education documents. You are required to maintain these documents for five years so that you can make them available to the Department upon request.

I certify that I have earned the approved continuing education credits listed on this form. I understand that the California Department of Public Health may cancel permits that are procured by fraud, misrepresentation, or mistake.

| | |
|-----------|------|
| Signature | Date |
|-----------|------|