Renewals will not be considered complete until both the renewal payment and continuing education credits have been received by the department.

Radiologic Technologist Renewal Check List:

1. Renewal Payment:

Return the completed Special Renewal Application (page 2) along with your **nonrefundable** renewal payment in the form of a check or money order made payable to "**CDPH-RHB**". The fees **per category** are as follows:

$104.00 per category if your certificate has not expired.
$120.00 per category if your certificate expired within the past six months.
$224.00 per category if your certificate expired within the past 5½ years.

Note: *Certificates cannot be renewed after 5½ years from the expiration date. You will need to reapply.*

2. Continuing Education Credits:

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. You are required to earn 24 approved continuing education credits within the past two years.

- Certified Radiologic Technologists must earn at least 4 of the 24 continuing education credits in digital radiography.
- Mammography Radiologic Technologists certificate holders must earn at least 10 of the 24 credits in mammography and 4 in digital radiography.
- Fluoroscopy Radiologic Technologists permit holders must earn at least 4 of the 24 credits in radiation safety for the clinical uses of fluoroscopy and 4 in digital radiography.

For further information on continuing education credit requirements, you may visit RHB Continuing Education Credits Requirements Page. Failure to provide a complete renewal, will delay the update of your certificate.

Do not submit copies of your certificates. You are required to maintain proof of continuing education for four years, to be provided upon request.

3. Mail your renewal payment and continuing education credits to:

Mailing Address:
CDPH-Radiologic Health Branch
Billing/Cashiering, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

Express Mail:
CDPH-Radiologic Health Branch
Billing/Cashiering, MS 7610
1500 Capitol Avenue
Sacramento, CA 95814-5006

A valid temporary authorization will be available to view and print for work purposes, within 24-48 hours after your completed renewal is processed, at RHB Certificate/Permit Search Tool.

SPECIAL RENEWAL APPLICATION

California Radiologic Technology Certificate

Certificate Number	Certificate Expiration Date	Phone Number
Last Name, Suffix	First Name	Middle Name
Social Security Number / ITIN	Date of Birth (MM/DD/YYYY)	Email Address
Mailing Address or P.O. Box Number ☐ Check if you are requesting to change your address		
City	State	Zip Code

Name change requests must be accompanied by a copy of a certified superior court order allowing the name change and a government issued picture ID, such as a driver's license, military ID, or passport. The information you provide on this form (except Social Security Numbers and Date of Birth) may be made public by the California Public Records Act; please provide a P.O. Box number or other alternate address and/or an alternate phone number if you do not wish to have your home address and/or phone number made public.

Please list the required 24 credits in the space provided below, accordingly. Complete extra copies of this application as needed to list the approved continuing education credits you have earned. Indicate the certifying organization letter below in "Group" *: (a) American Registry of Radiologic Technologists (ARRT), (b) Medical Board of California, (c) Osteopathic Medical Board of California, (d) Podiatric Medical Board of California, (e) California Board of Chiropractic Examiners, (f) Dental Board of California.

Course Title				
Provider or Sponsor	Provider Contact Information	Date	*Group Select	Hours
Course Title				
Provider or Sponsor	Provider Contact Information	Date	*Group Select	Hours
Course Title				
Provider or Sponsor	Provider Contact Information	Date	*Group Select	Hours
Course Title				
Provider or Sponsor	Provider Contact Information	Date	*Group Select	Hours

REQUEST FOR CANCELLATION (optional)

Please note: If you request to cancel your certificate, you are not eligible for reinstatement and will need to reapply for a new certificate.

☐ I wish to cancel one or more of my certificate categories. Please cancel the following certificate categories:

☐ I wish to cancel **ALL** of my certificate(s). (*Do not submit payment*)

I certify that the information provided in this application for renewal is true and correct. I understand that the California Department of Public Health may revoke certificates or permits that are procured by fraud, misrepresentation, or mistake, or 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 certified pursuant to the Radiologic Technology Act, I am acting within the scope of that certification, and I am acting under the supervision of a licentiate of the healing arts who is a certified supervisor or operator.

Signature (Original Signature Required)	Date