THE AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS®

DUPLICATE EXAMINATION SCORE REPORT AUTHORIZATION

INSTRUCTIONS

(1) Print legibly and complete the form. Illegible or incomplete forms will be returned without processing.

(2) You must be currently certified and registered to request a duplicate score report. Individuals not certified and registered can request duplicate fail score reports only.

(3) Specify how many score reports you are requesting and for which discipline(s) in the "Request Statement" section. Unless you provide a different mailing address, ARRT will automatically mail the reports to your address on file.

(4) The score reports will bear your legal name as currently on record at ARRT, along with your original certificate number and the exam date.

(5) If your name has changed, you must include acceptable documentary evidence of your name change and a Name Change Form. The new name to be printed on the duplicate certificate should be printed legibly. You can find the Name Change Form by visiting arrt.org and clicking on the forms icon located on the homepage.

(6) Enclose a personal check or money order of $15 for 1-3 duplicate score reports, or $30 for 4-6 duplicate score reports.

(7) Complete the application. Incomplete applications will be returned.

(8) Mail the original application (photocopies not accepted) to ARRT, Education Requirements Department, 1255 Northland Drive, St Paul, MN 55120-1155.

(9) Allow three to four weeks for delivery.

(10) To be valid, duplicate score reports must be embossed with the official seal of ARRT.

DUPLICATE EXAMINATION SCORE REPORT APPLICATION

Read instructions on Page 1 before completing this application.

ARRT ID Number | U.S. Social Security Number – – | Birthdate MM DD YYYY

Last Name

First Name | Middle Initial

Street Address 1

Street Address 2

City | State | Zip

Phone Number - -

If your name has changed, please provide name as originally certified. (For ARRT verification)

Last Name

First Name | Middle Initial

REQUEST STATEMENT: FILL IN THE BLANKS BELOW

Mail _____ duplicate score report(s) for _____ to:

(Number of Reports) (Discipline(s) i.e. Radiography, Nuclear Medicine, etc.)

Mail to the above address (check box). ☐

Name / Company _____

Attn _____

Street Address _____

City _____ State _____ Zip _____

I DECLARE THAT ALL THE DATA APPEARING ON THIS APPLICATION ARE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

_____ MM DD YYYY

(Applicant Signature)