# X-ray Technician Podiatric Radiography (POD) Permit Application

**(Failure to provide your full legal name may result in denial of entrance into the examination)**

| Last Name (Please Print) | First Name | Middle Name | |
|---|---|---|---|
| Date of Birth | SSN or ITIN* | Phone Number | |
| Mailing Address (Number and Street or P.O. Box Number) | | E-mail Address | |
| City | | State | Zip Code |

*Social Security Number or Individual Taxpayer Identification Number

Pursuant to the authority found in Section 114871 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the SSN/ITIN is mandatory. The SSN/ITIN 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. The information you provide on this form (except for SSN/ITIN) may be made public under the California Public Records Act; please provide a P.O. Box number or other alternate address if you do not wish to have your home address made public. This information may also be provided to the American Registry of Radiologic Technologists (ARRT) for examination purposes. For information or access to your records, contact the Certification Support Unit at the California Department of Public Health, Radiologic Health Branch (CDPH-RHB), MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

**REQUIREMENTS:**
**To obtain a California X-ray Technician Podiatric Radiography Permit, you must submit this application along with the following:**

- A copy of your graduation diploma or certificate from a CDPH-RHB approved Limited Podiatric Radiography Educational Program.
- The non-refundable application fee of $112.00 in the form of a check (e.g., personal, cashier's, or certified check) or money order made payable to CDPH-RHB.

Please mail this application, all supporting documents, and payment for the non-refundable application fee of $112.00 to:

**USPS First-Class Mail:**
**California Department of Public Health**
**Radiologic Health Branch, MS 7610**
**Accounts Receivable and Cashiering Unit**
**P.O. Box 997414**
**Sacramento, CA 95899-7414, *or***

**Express Mail:**
**California Department of Public Health**
**Radiologic Health Branch, MS 7610**
**Accounts Receivable and Cashiering Unit**
**1500 Capitol Ave., Suite 520, Bldg. 172**
**Sacramento, CA 95814-5006**

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| Last Name (Please Print) | First Name | Middle Name |
|---|---|---|
| | | |

**NOTIFICATION OF APPLICATION STATUS**

Within 30 calendar days of receipt of your application, CDPH-RHB will mail you a notification letter which will inform you of the following:

- Your application is acceptable for filing and instructions regarding the next steps in the examination process; or
- Your application is *not* acceptable for filing and the next steps to correct deficiencies.

*I certify that the information provided with this application is true and correct. I understand that the California Department of Public Health may revoke 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 have been granted a permit pursuant to the Radiologic Technology Act, acting within the scope of that permit, and acting under the supervision of a licensed podiatrist who holds a radiography supervisor and operators permit.*

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