

APPLICATION FOR RADIOLOGIC TECHNOLOGY QUALITY CONTROL TESTING			DATE
PRIVACY ACT STATEMENT			
<i>AUTHORITY: 10 U.S.C. 8013, Secretary of the Air Force; powers and duties.</i>			
<i>PURPOSE; To ensure the individual meets qualifications to take Radiologic technology Quality Control Test. The SSN is used for positive identification of individual.</i>			
NAME (Last, First, Middle Initial)		MAIDEN NAME (if applicable)	GRADE
SSN		STATUS <input type="checkbox"/> ADAF <input type="checkbox"/> RESERVE <input type="checkbox"/> ANG <input type="checkbox"/> RETIREE	
HOME ADDRESS (Number, Street, City, State, Zip Code)		HOME TELEPHONE NO. (include Area Code)	
ORGANIZATION ADDRESS(Active duty military only)		OFFICE TELEPHONE NO. (DSN)	
NAME AND LOCATION OF NEAREST ACTIVE USAF BASE(Nonactive duty military only)			
RESUME OF EXPERIENCE IN RADIOLOGIC TECHNOLOGY			
<i>NOTE: Your application will be unacceptable unless ALL INFORMATION IS PROVIDED. An incomplete application can result in postponement of your examination to the next examination period or the results of the Quality Control Test will be withheld until all of the support documents are on file at 381 TRS/CSX. PRINT OR TYPE ALL INFORMATION.</i>			
DATE ENTERED AIR FORCE	DATE OF SEPARATION	DATE ENTERED RADIOLOGY	NO. YEARS OF EXPERIENCE
DID YOU ATTEND PHASE I? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU ATTEND PHASE II? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHEN? _____		WHEN? _____	
HAVE YOU COMPLETED THE 5 LEVEL CDC? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHEN? _____ (atch copy of certificate)			
HAVE YOU PREVIOUSLY TAKEN THE USAF QUALITY CONTROL TEST?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE? _____ WHEN? _____ NO. TIMES _____			
IF YOU DID NOT ATTEND ANY OF THE ABOVE COURSES, WHERE DID YOU RECEIVE YOUR TRAINING IN RADIOLOGIC TECHNOLOGY?			
NAME AND LOCATION OF THE RADIOLOGIST YOU WORKED UNDER FOR PHASE III TRAINING(include phone number, if know, dates and location of training)			
GIVE A CHRONOLOGICAL LISTING OF WHERE YOU WEE STATIONED. HOW LOG YOU SERVEC AT EACH STATI(include dates, if possible). AND A BRIEF DESCRIPTION OF THE TYPE OF DUTIES YOU PERFORMED. (if more space is required, continue on reverse of this form.) form.)			

*The minimum passing score for the USAF Quality Control Test is 70%.

SEND APPLICATIONS TO: ATTN: RADIOLOGY Q.C. MONITOR
381 TRS/XWBF
917 MISSILE RD
SHEPPARD AFB TX 76311-2246

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