Texas Department of State Health Services

RC Form 255-3 APPLICATION FOR INDUSTRIAL RADIOGRAPHY EXAMINATION

INSTRUCTIONS: Submit this original form with the **non-refundable, non-transferable fee stated below**, payable to the Texas Department of State Health Services, in accordance with Title 25 Texas Administrative Code § 289.255.

1. Applicant Full Name: (Last, First, Middle)		2. Social Security Number:
3. Applicant Address: (Street Address, City, State, Zip Code)		
Applicant Email Address:		
4. Applicant Contact Numbers Phone: Fax:	5. Date of Birth:	6. Mail Results/ ID Card to: ☐ Residence ☐ Employer

7. Present Employer (If Applicable)	License/Registration No.:
Company Name:	Co. Email:
Mailing Address:	Co. Phone:
City, State, Zip Code:	Co. Fax:

8. Type of Examination (Check One)	9. Category of Examination (Check One)
☐ Initial Examination ($120.00) ☐ Re-Examination ($120.00)	☐ 1 - Radioactive Materials Only (RAM) ☐ 2 - X-Ray Machines Only ☐ 3 - Both (RAM & X-Ray)
☐ Re-Certification Exam ($124.00) Issued by: Audit No.: Expires:	

10. Certification – I certify the above information is correct to the best of my knowledge.	
Signature:	Date:

Send the application with applicable fee to:

Texas Department of State Health Services
Business Filing and Verification – MC 2003
P.O. Box 149347
Austin, Texas 78714-9347

For Agency Use Only

Documents on File:

☐ 255-E

☐ 255-R/OS (RAM)

☐ 255-R/OS (X-Ray)

☐ Prior Approval from Business Filing and Verification after Suspension or Revocation of ID Card.

Examination Date: ____________________

Examination Code No.: _______________

Final Grade: ________________________

File No.: ___________________________

Entity No.:___________________________

Application No.: _____________________

License No.: ________________________

CRCPD ID No.: ______________________

Qualification Code: ___________________

Trainer Code: _______________________

Expiration Date: _____________________

Certificate No.: ______________________

Date ID Card Mailed: _________________

Date Results Mailed: _________________

DSHS Representative's Signature: