

SCHOOL OF DIAGNOSTIC IMAGING

Cleveland Clinic

18901 Lake Shore Blvd, Euclid, OH 44119

(216) 692-7523

Fax (216) 692-7663

APPLICATION FOR ADMISSION

Admittance is on a first come, first serve basis until course is filled. Please indicate which program and/or course(s) you are applying for as well as your availability (check all that apply):

Programs	Days	Evenings
MRI Program (including 450 clinical hours)		
CT Program (including 450 clinical hours)		
Individual Courses		
Introduction to CT / MRI		
Cross Sectional Anatomy and Pathology		
MRI Physics		
CT Physics		

You are urged to give careful consideration to each question on this form. It is to your advantage to fill out the application completely and return it promptly to the School of Diagnostic Imaging. A \$20 non-refundable application fee must accompany this form.

Print or type all information below. **Please include your legal name only.**

Date: _____ Social Security No.: _____

Name: _____
Last Name (Former) First Middle

Home Address: _____
Street

_____ City State Zip Code

Phone: _____
Home Work E-mail

The following section contains questions that bear upon your ability to sit for registry examination:

Are you a U.S. citizen? Yes _____ No _____

Have you ever been convicted, pled guilty or no contest to any felony? Yes _____ No _____

If yes, explain: _____

Have you ever been convicted, pled guilty or no contest to any misdemeanor? Yes _____ No _____

If yes, explain: _____

*The above conditions may prevent an applicant from becoming registered. These applicants are encouraged to contact the American Registry of Radiologic Technologists, (651) 687-0048, to determine examination eligibility.

Are you registered in Radiologic Technology with the ARRT and in good standing? Yes _____ No _____

If yes, please include a copy of you ARRT card(s). If **NOT**, please provide radiology school transcripts and state the date you intend to take registry. _____

Our clinical sites require Cardiopulmonary Resuscitation (CPR) certification. Are you currently certified in CPR?

Yes _____ No _____ Please include a copy of your certification card.

By what method did you learn of the CT / MRI Program?

Newspaper _____ Friend _____ Brochure _____
Yellow pages _____ Work _____ Other (please specify) _____

Education

POST SECONDARY EDUCATION: List ALL education beyond high school. (Include all courses in which you are currently enrolled.)

Dates		Name of Institution	City / State	Major	Diploma / Degree
From	To				

Employment History

EMPLOYMENT: List ALL work experiences, both full and part-time, since high school, beginning with the most recent. Indicate an individual who may be contacted for reference.

Dates		Name of Institution	City / State	Position	Contact name and phone number
From	To				

PLEASE READ CAREFULLY - APPLICANT'S CERTIFICATION AND AGREEMENT

I certify that all my answers and statements herein are complete and true. I understand that any falsification or omission may cause my application to be rejected, or my enrollment to be terminated. I hereby authorize my former employers to furnish their records of my service, my reason for leaving their employ, together with all information they may have concerning me whether written or verbal. I release my former employer, its officers, agents and employees, from any liability whatsoever for releasing such information or opinion. I realize that receipt of a poor reference or failure to successfully complete a physical examination and/or drug test may cause my application to be rejected or my enrollment to be terminated. I agree that nothing in this application for the School of Diagnostic Imaging, or said to me, or contained in the written materials given to me, is intended to be an offer or promise or agreement by the School of Diagnostic Imaging or the Cleveland Clinic to enroll me for any specified period of time.

Signature of Applicant

Date