SCHOOL OF DIAGNOSTIC IMAGING POST PRIMARY
COMPUTED TOMOGRAPHY (CT) / MAGNETIC RESONANCE IMAGING (MRI) PROGRAMS
APPLICATION FOR ADMISSION

PERSONAL DATA

Last Name ___________________________ First _______________ Middle _____________
Maiden ________________________________
Address _______________________________ City _______________ State ________ Zip _______
Home Phone Number ___________________________ Cell Phone Number ___________________________
E-Mail Address (Required)

Admittance is on a rolling basis until course is filled. Please indicate which program and/or course(s) you are applying for (check all that apply):

<table>
<thead>
<tr>
<th>PROGRAMS</th>
<th>CHECK HERE</th>
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<tbody>
<tr>
<td>MRI Program (including 500 clinical hours)</td>
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<tr>
<td>CT Program (including 500 clinical hours)</td>
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If intending to complete both CT & MRI programs, please indicate which program you will participate in first.

□ CT Program first
□ MRI Program first

INDIVIDUAL COURSES ONLY

Introduction to CT / MRI
Cross Sectional Anatomy and Pathology
MRI Physics
CT Physics
CT or MRI Clinical Course

A $20 non-refundable application fee must accompany this form. Check or credit/debit card only. Call 216-448-3110 to process application fee.

GENERAL

How did you become aware of School of Diagnostic Imaging’s CT/MRI Program?

□ Brochure
□ Internet
□ Former Student
□ Friend/Relative/Co-Worker
□ Other: please explain ___________________________ ________________

IMPORTANT INFORMATION

If you have a record of criminal conviction of a crime, including a felony, alcohol and/or drug related violations, a gross misdemeanor or misdemeanors with the sole exception of speeding and parking violations, criminal proceedings where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered, or a criminal proceeding where the individual enters a plea of guilt or nolo contendere, military court-martial that involves: substance abuse, sex-related infractions or patient-related infractions, or have pending litigation, these conditions may prevent an applicant from becoming registered. These applicants are encouraged to contact the American Registry of Radiologic Technologists at (651) 687-0048, or at www.arrt.org to determine examination eligibility.

FOR SCHOOL OF DIAGNOSTIC IMAGING USE ONLY

Date Submitted: ___________ Date Completed: ________________
Acceptance Letter Sent: □ Yes □ No
Requirement checklist: □ Yes □ No
Student data sheet: □ Yes □ No
Application Fee Paid: □ Yes □ No
In Grad Pro: □ Yes □ No
Acceptance Fee Paid: □ Yes □ No
In Roster: □ Yes □ No
EDUCATION

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

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<th>DATES FROM</th>
<th>TO</th>
<th>NAME OF INSTITUTION</th>
<th>CITY/STATE</th>
<th>MAJOR</th>
<th>DIPLOMA/DEGREE</th>
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EMPLOYMENT HISTORY

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<th>YEARS FROM</th>
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<th>NAME OF COMPANY/INSTITUTION</th>
<th>CITY/STATE</th>
<th>POSITION</th>
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REGISTRATION INFORMATION

You must have current ARRT or equivalent registration and BLS for Health Care Provider. Documentation will be required upon acceptance into the program.

Are you a registered technologist?  □ Yes  □ No
If you are a registered technologist, in which modality are you currently registered?

□ Radiography  □ Nuclear Medicine  □ Ultrasound  □ Radiation Therapy

Please include a copy of your ARRT or equivalent card

If you are not a registered technologist please provide imaging program transcripts and indicate the date you intend to take the registry: __________________________

AGREEMENT

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 realize that failure to successfully complete a physical examination 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 ________________

Cleveland Clinic is committed to providing a working and learning environment in which all individuals are treated with respect and dignity. It is the policy of Cleveland Clinic to ensure that the working and learning environment is free from discrimination or harassment on the basis of race, color, religion, gender, sexual orientation, gender identity, pregnancy, marital status, age, national origin, disability, military status, citizenship, genetic information, or any other characteristic protected by federal, state, or local law. Cleveland Clinic prohibits any such discrimination, harassment, and/or retaliation. In addition, Cleveland Clinic shall provide reasonable accommodations to any qualified student with a disability in order for the student to have equal access to their program. Students needing a reasonable accommodation in order to apply to or participate in the program should contact the program director as early as possible.