

SCHOOL OF DIAGNOSTIC IMAGING
DIAGNOSTIC MEDICAL SONOGRAPHY PROGRAM
APPLICATION FOR ADMISSION

PERSONAL DATA

Last Name _____ First _____ Middle _____
 Maiden _____
 Address _____ City _____ State _____ Zip _____
 Home Phone Number _____ Cell Phone Number _____
 E-Mail Address (Required) _____

GENERAL

How did you become aware of the Diagnostic Medical Sonography Program offered at the School of Diagnostic Imaging?

- | | | |
|---|--|--|
| <input type="checkbox"/> Former Student | <input type="checkbox"/> Lakeland Community College | <input type="checkbox"/> Kent State University |
| <input type="checkbox"/> Friend/Relative/Co-Worker | <input type="checkbox"/> Cuyahoga Community College | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Lorain County Community College | |
| <input type="checkbox"/> 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 schedule a meeting with the program director and to contact the American Registry of Diagnostic Medical Sonography at (301) 738-8401 or at www.ardms.org to determine examination eligibility.

FOR SCHOOL OF DIAGNOSTIC IMAGING USE ONLY

Current College Degree: _____	Date Application Submitted: _____
<input type="checkbox"/> High School Transcripts	<input type="checkbox"/> College Transcripts
<input type="checkbox"/> Medical Terminology	<input type="checkbox"/> Application Fee Paid
<input type="checkbox"/> Anatomy & Physiology I	<input type="checkbox"/> Entered into Grad Pro
<input type="checkbox"/> Anatomy & Physiology II	<input type="checkbox"/> Observation Information Sent
<input type="checkbox"/> Math	<input type="checkbox"/> Acceptance Fee Paid
<input type="checkbox"/> Physics	Date of Observation: _____
<input type="checkbox"/> Communications	Date of Interview: _____
Date Application Complete: _____	Response Deadline: _____
Initials: _____	

EDUCATION

SCHOOLS ATTENDED	NAME AND CITY/STATE OF SCHOOL	YEAR GRADUATED	DEGREE AWARDED
High School(s)			
College(s)			

PROGRAM PREREQUISITIES & APPLICATION CHECKLIST

**All prerequisite courses must be college-level and completed with a "C" grade or better:
See program officials for specific prerequisite requirements.**

- | | |
|--|---|
| <input type="checkbox"/> Medical Terminology | <input type="checkbox"/> Math |
| <input type="checkbox"/> Anatomy & Physiology I | <input type="checkbox"/> Physics |
| <input type="checkbox"/> Anatomy & Physiology II | <input type="checkbox"/> Communications |

- \$20.00 Non-Refundable Application Fee – Check or Debit/Credit only. Call 216-448-3110 to process payment.**

- Send Official High School and College Transcripts:**

School of Diagnostic Imaging
25900 Science Park Drive Building 2
Beachwood, Ohio 44122 - Mail Code AC239

EMPLOYMENT HISTORY

DATES FROM - TO	NAME OF COMPANY/INSTITUTION	CITY AND STATE	POSITION

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.