Cleveland Clinic
School of Health Professions
Computed Tomography & Post-Primary
Magnetic Resonance Imaging Programs

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Magnetic Resonance Imaging Programs
25900 Science Park Drive - Building 2
Beachwood, Ohio 44122 - Mail Code AC239
saghyk@ccf.org

COMPUTED TOMOGRAPHY / POST- PRIMARY MAGNETIC RESONANCE IMAGING 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):

PROGRAMS	CHECK HERE
Post-Primary MRI Program (including 500 clinical hours)	☐
CT Program (including 500 clinical hours)	☐
If intending to complete <u>both</u> CT & Post-Primary MRI programs, please indicate which program you will participate in <u>first.</u>	☐ CT Program first ☐ PPMRI 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. Make checks payable to Cleveland Clinic School of Health Professions and send to: The Cleveland Clinic Foundation, PO BOX 373291, Cleveland, OH, 44193-3291. Call 216-448-3110 to process application fee by credit/debit.

GENERAL

How did you become aware of the CT/POST-PRIMARY MRI Programs?

☐ 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 PROGRAM USE ONLY

Date Submitted: _____ Date Completed: _____ Application Fee Paid: ☐Yes ☐No

Acceptance Letter Sent: ☐Yes ☐No In Grad Pro: ☐Yes ☐No

Requirement checklist: ☐Yes ☐No Acceptance Fee Paid: ☐Yes ☐No

Student data sheet: ☐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).

DATES FROM	TO	NAME OF INSTITUTION	CITY/STATE	MAJOR	DIPLOMA/DEGREE

EMPLOYMENT HISTORY

YEARS FROM	TO	NAME OF COMPANY/INSTITUTION	CITY/STATE	POSITION

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 information submitted in the admissions process, including this application and any other supporting materials, is my own work, factually true, and honestly presented, and that these documents will become property of the School of Health Professions and will not be returned to me. I understand that I may be subject to a range of possible disciplinary actions, including admission revocation, expulsion, or revocation of course credit, grades, and certificate should the information I have certified be false. I agree to notify the School of Health Professions immediately should there be any change to the information requested in this application.

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.