Cleveland Clinic
School of Health Professions
Computed Tomography Program

Supplemental Application

Computed Tomography

General Information

First Name: _____ Last Name: _____

Email Address: _____ Phone: _____

Registration Information

I plan to attend both CT and MRI courses: Yes: ☐ No: ☐

If yes, indicate which program you will be attending first: _____

I am a registered technologist: Yes: ☐ No: ☐

If yes, indicate which modality:

- ☐ Nuclear Medicine
- ☐ Radiation Therapy
- ☐ Radiography
- ☐ Ultrasound

If you are not registered, please indicate expected registry exam date: _____

I certify that all information submitted in the admission process, including this application and any other supporting materials, is my own work, factually true, and honestly presented, and that these documents will become the property of the School of Health Professions and will not be returned to me. I am aware I must meet health and background check requirements in order to begin my program. 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 provided be false. I agree to notify the School of Health Professions immediately should there be any change to my criminal history or the information requested in this application.

Signature: _____ Date: _____

CTProgram@ccf.org