

**Supplemental Application**  
**Medical Dosimetry Program**

**General Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Education History and Registration Information**

Radiation Therapy Program: \_\_\_\_\_ GPA: \_\_\_\_\_

Program Director name: \_\_\_\_\_

Scholastic honors and/or scholarships:

Professional publications and/or posters presented:

Professional memberships:

**Employment and References**

I have worked in a radiation oncology department: Yes: No:

If yes, indicate name of facility and supervisor:

## Essay

Please indicate why you are applying to the Cleveland Clinic School of Health Professions Medical Dosimetry Program:

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: \_\_\_\_\_