

**SCHOOL OF DIAGNOSTIC IMAGING  
RADIOLOGIC TECHNOLOGY 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 Radiologic Technology 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 Radiologic Technologists at (651) 687-0048, or at [www.arrt.org](http://www.arrt.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"/> Application Fee Paid
<input type="checkbox"/> College Transcripts	<input type="checkbox"/> Entered into Grad Pro
<input type="checkbox"/> Medical Terminology	<input type="checkbox"/> Observation Info Sent
<input type="checkbox"/> Anatomy & Physiology I	<input type="checkbox"/> Acceptance Fee Paid
<input type="checkbox"/> Anatomy & Physiology II	Date of Observation: _____
<input type="checkbox"/> Anatomy & Physiology for Medical Imaging at Tri-C	Date of Interview: _____
Date Application Complete: _____	Date Acceptance Letter Sent: _____
Initials: _____	Response Deadline: _____

**EDUCATION**

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

**PROGRAM PREREQUISITES AND APPLICATION CHECKLIST**

All college-level prerequisite courses must be completed with a "C" grade or better:

Additional general education courses are required for degree completion. See program officials for requirements.

- Medical Terminology**
- Anatomy & Physiology I and Anatomy & Physiology II**
- or Anatomy & Physiology for Medical Imaging at Cuyahoga Community College**
- \$20.00 Non-Refundable Application Fee – Check or Debit/Credit only. Call 216-692-7512 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.