Cleveland Clinic
School of Diagnostic Imaging

Euclid Hospital
Health Center Building
18901 Lakeshore Boulevard
Euclid, Ohio 44119

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SCHOOL OF DIAGNOSTIC IMAGING

RADIOLOGIC TECHNOLOGY PROGRAM
APPLICATION FOR ADMISSION

PERSONAL DATA

Last Name ______________________ First ______________ Middle ______________

Maiden ______________________

Address ______________________ City ______________ State ________ Zip ________

Home Phone Number ______________________ Work Telephone 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?

- ☐ Former Student
- ☐ Friend/Relative/Co-Worker
- ☐ Internet
- ☐ Lakeland Community College
- ☐ Cuyahoga Community College
- ☐ Lorain County Community College
- ☐ Kent State University
- ☐ Newspaper
- ☐ Phone Book
- ☐ 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 to determine examination eligibility.

FOR SCHOOL OF DIAGNOSTIC IMAGING USE ONLY

Current College Degree:______________

- ☐ High School Transcripts
- ☐ College Transcripts
- ☐ Medical Terminology
- ☐ Anatomy & Physiology I
- ☐ Anatomy & Physiology II
- ☐ Anatomy & Physiology for Medical Imaging at Tri-C

Date Application Complete: ______________

Initials: ____________

Date Application Submitted:______________________

- ☐ Application Fee Paid
- ☐ Entered into Grad Pro
- ☐ Observation Info Sent
- ☐ Acceptance Fee Paid

Date of Observation:______________________

Date of Interview:______________________

Date Acceptance Letter Sent: ______________________

Response Deadline:______________________

12/18

EDUCATION

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

PROGRAM PREREQUISITES AND APPLICATION CHECKLIST

All college-level prerequisite courses must be completed by February 1st 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**
- ☐ **Sent Official High School and College Transcripts:**
  School of Diagnostic Imaging
  Euclid Hospital Health Center
  18901 Lakeshore Blvd.
  Euclid, Ohio 44119

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 does not discriminate in admission, employment, or administration of its programs or activities, on the basis of age, gender, race, national origin, religion, creed, color, marital status, physical or mental disability, pregnancy, sexual orientation, gender identity or expression, genetic information, ethnicity, ancestry, veteran status, or any other characteristic protected by federal, state or local law. In addition, Cleveland Clinic administers all programs and services without regard to disability, and provides reasonable accommodations for otherwise qualified disabled individuals.