Cleveland Clinic
School of Diagnostic Imaging

Euclid Hospital
Health Center Building
18901 Lake Shore Boulevard
Euclid, Ohio 44119

Phone: 216.692.7512
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SCHOOL OF DIAGNOSTIC IMAGING

RADIOLOGIC TECHNOLOGY PROGRAM
APPLICATION FOR ADMISSION

PERSONAL DATA

Last Name ______________________ First ______________ Middle ______________

Maiden ______________________ Social Security Number ______________________

Address ______________________ City ______________ State ________ Zip ________

Home Phone Number ______________________ Work Telephone Number ______________________

Cell Phone Number ______________________ E-Mail Address (Required) ______________________

GENERAL

How did you become aware of School of Diagnostic Imaging's Radiologic Technology Program?

☐ Brochure ☐ Lakeland Community College ☐ Former Student

☐ Friend/Relative/Co-Worker ☐ Cuyahoga Community College ☐ H.S. Career Counselor

☐ Internet ☐ Phone Book ☐ Newspaper

☐ 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, 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 SCHOOL OF DIAGNOSTIC IMAGING USE ONLY

High School Transcripts ☐ Yes ☐ No

College Transcripts ☐ Yes ☐ No

Algebra or Higher Level Math ☐ Yes ☐ No

Anatomy & Physiology I ☐ Yes ☐ No

Anatomy & Physiology II ☐ Yes ☐ No

English Composition ☐ Yes ☐ No

Medical Terminology ☐ Yes ☐ No

Psychology ☐ Yes ☐ No

BLS for Healthcare Providers American Heart Association ☐ Yes ☐ No

Date Application Submitted: ______________

Application Fee Paid: ☐ Yes ☐ No

Observation Info Sent: ☐ Yes ☐ No

Observation Date: ______________

Interview Date: ______________

Acceptance Letter Sent: ☐ Yes ☐ No

Response Deadline: ______________

Acceptance Fee Paid: ☐ Yes ☐ No

In Grad Pro: ☐ Yes ☐ No

EDUCATION

LIST ALL SCHOOLS COMPLETED	NAME AND ADDRESS OF SCHOOL	YEARS COMPLETED	YEAR GRADUATED
High School(s)			
College(s)			

PROGRAM PREREQUISITES

The following college-level prerequisites must be completed by February 1st with a "C" grade or better:

- **Algebra** or higher level math ☐ Yes ☐ No
- **Anatomy & Physiology I and Anatomy & Physiology II** - Completed within the last ten years ☐ Yes ☐ No
- **English Composition** - or an equivalent approved ☐ Yes ☐ No
- **Medical Terminology** ☐ Yes ☐ No
- **Psychology** ☐ Yes ☐ No
- **Basic Life Support (BLS) for Healthcare Providers - AHA** ☐ Yes ☐ No

Please have official High School and College/University transcripts sent to:
($20.00 non-refundable application fee)

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EMPLOYMENT HISTORY

DATES FROM	TO	NAME OF COMPANY/INSTITUTION	CITY/STATE	POSITION	PHONE NUMBER

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 hereby authorize my former employers to furnish their records of my service, my reason for leaving their employ, together with all information they may have concerning me whether written or verbal. I release my former employer, its officers, agents and employees, from any liability whatsoever for releasing such information or opinion. I realize that receipt of a poor reference, or failure to successfully complete a physical examination and/or drug test 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.