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
STUDENT APPLICATION

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 _____

Person to Notify in Case of Emergency:

Name _____

Address _____ City _____ State _____ Zip _____

Work Telephone Number _____ Home Telephone Number _____

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 _____

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 _____

EDUCATION

Circle Highest Grade Completed: High School: 9 10 11 12 College or University: 1 2 3 4 5 6

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

PROGRAM PREREQUISITES

The following college-level prerequisites must be completed by February 1st:

Algebra or higher level math with a "C" grade or better, completed within the last ten years ☐ Yes ☐ No

Anatomy & Physiology I and Anatomy & Physiology II with a "C" grade or better, completed within the last ten years ☐ Yes ☐ No

College Composition with a "C" grade or better, or an equivalent course approved by the School of Diagnostic Imaging ☐ Yes ☐ No

Medical Terminology with a "C" grade or better ☐ Yes ☐ No

Psychology with a "C" grade or better ☐ Yes ☐ No

Please have official High School and College/University transcripts sent to:

School of Diagnostic Imaging
Euclid Hospital
18901 Lake Shore Blvd.
Euclid, Ohio 44119

SUBMIT THIS APPLICATION TO THE SCHOOL WITH A NON-REFUNDABLE $20 APPLICATION FEE

EMPLOYMENT HISTORY

COMPLETE ALL PRESENT AND PAST EMPLOYMENT, BEGINNING WITH YOUR MOST RECENT

Name of Company/Hospital	Position(s) Held - (Specify, if part time, how many hours worked per week)	Highest Salary Each Position	From		To		Reason for Leaving
Address			Month	Year	Month	Year	
Telephone							
Name of Last Supervisor							
Type of Business, If Not Hospital							
Briefly Summarize Experience Gained, Including Special Training you Received							

Name of Company/Hospital	Position(s) Held - (Specify, if part time, how many hours worked per week)	Highest Salary Each Position	From		To		Reason for Leaving
Address			Month	Year	Month	Year	
Telephone							
Name of Last Supervisor							
Type of Business, If Not Hospital							
Briefly Summarize Experience Gained, Including Special Training you Received							

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Address			Month	Year	Month	Year	
Telephone							
Name of Last Supervisor							
Type of Business, If Not Hospital							
Briefly Summarize Experience Gained, Including Special Training you Received							

All applicants are considered equally for admission without regard to religion, age, race, color, sex, or ethnic origin.
The School of Diagnostic Imaging guarantees equal opportunity for all.

PERSONAL INFORMATION

Do you have any physical or mental condition or disability which would substantially interfere with your ability to perform the duties of a Radiographer? (State law prohibits discrimination based on a handicap.)

☐ Yes ☐ No If yes, describe the mental or physical condition or disability and explain the limitation as it pertains to the requirements of a radiographer. Also, describe any specific accommodation(s) we could make. _____

Do 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?

☐ Yes ☐ No If your answer is yes, please explain: _____

Are you a U.S. citizen ☐ Yes ☐ No
Resident Alien ☐ Yes ☐ No
Visa Status ☐ F1 ☐ M1 ☐ Other, please describe _____

The above conditions may prevent an applicant from becoming registered. These applicants are encouraged to contact the American Registry of Radiologic Technologists at (651) 687-0048, to determine examination eligibility.

ADDITIONAL INFORMATION

Occasionally, an application form makes it difficult for an individual to adequately summarize his/her complete background. Use the space below to summarize any additional information necessary to describe your full qualifications.

GOALS

Describe your short and long term educational and professional goals: _____