Cleveland Clinic

Medical Dosimetry Program (CA-50)
9500 Euclid Avenue, Cleveland, Ohio 44195 5213

APPLICATION FOR ADMISSION

DATE _____

Name _____
Last First M.I.

Previous Name(s) If Applicable _____

Address _____
City State Zip Code

Social Security Number _____

Phone # _____ /_____ # Where Message May Be Left _____ /_____
Area Code

Educational Data

Radiation Therapy Program _____

City_____ State_____ Zip Code_____ Dates Attended_____

College(s)

Name _____

City_____ State_____ Zip Code_____ Dates Attended_____

Name _____

City_____ State_____ Zip Code_____ Dates Attended_____

Name _____

City_____ State_____ Zip Code_____ Dates Attended_____

Name _____

City_____ State_____ Zip Code_____ Dates Attended_____

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Scholastic Honors, Scholarships _____

Professional Publications, Posters Presented _____

Professional Memberships _____

Date Of Radiation Therapy A.R.R.T. Examination (Completed/Anticipated) _____

ARRT# If Applicable _____ Expiration Date _____

Licenses Held: Lic# State _____ Expiration Date _____

References

Radiation Therapy Program Director _____
Name

_____
Address City State Zip Code

Present Or Most Recent Employer _____

_____
Name Of Supervisor Address City State Zip Code

Have You Ever Worked In A Radiation Oncology Department? _____

_____
Name Of Supervisor Address City State Zip Code

If Yes, Complete The Following: _____
Name Of Supervisor Facility Address City State Zip Code

What Is Your Reason For Applying To The Cleveland Clinic Medical Dosimetry Program?

(Please Attach A Separate Page)

I Authorize The Program Director To Contact The Above Named Individuals And Those Listed On My Resume As References.

I Understand That Upon Completion Of Training, The Cleveland Clinic Foundation Is Not Obligated To Employ Former Students As Medical Dosimetrists.

_____ _____
Signature Of Applicant Date