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 # With Area Code _____

Email Address _____

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 _____

Scholastic Honors, Scholarships _____

Professional Publications, Posters Presented _____

Professional Memberships _____

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

A.R.R.T. # 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? 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, Cleveland Clinic Is Not Obligated To Employ Former Students As Medical Dosimetrists.

_____ _____
Signature Of Applicant Date