



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