SwedishAmerican CT / MR Application

Choose which track you are applying for:

CT________ or MRI________

Name:____
(First) (Middle Initial) (Last)

Mailing Address: ____
(Street address/apt no./P.O. Box)

____
(City) (State) (Zip)

Date of Birth:___________________ County of Residence:___________________________________

Telephone #:________________________________ Cell Phone #:______________________________

Email address:____

Are you ARRT registered? Yes_______ No_________

Are you in good standing with the ARRT? Yes_________ No_________

If no, please explain:____

____

ARRT #:_____________________

When did you graduate from radiography school?____________

How many years of clinical experience do you have in radiography?___________

Are you IEMA Licensed? Yes_______ No_________

IEMA #:_____________________

Hospital/Clinic you are employed at:____

Name and telephone number of your supervisor or director:

Name:____

Telephone #:____

Please email this completed application to csalsbury@swedishamerican.org