

CARTI RADIATION THERAPY PROGRAM APPLICATION FOR ADMISSION

ALL REQUIRED DOCUMENTS ARE TO BE MAILED TO: CARTI RADIATION THERAPY PROGRAM, P.O. BOX 55050, LITTLE ROCK, AR 72215, AND POSTMARKED BY THE FIRST WORKING DAY OF MARCH TO BE CONSIDERED AS AN APPLICANT ELIGIBLE FOR INTERVIEW FOR THE FALL CLASS.

NAME:

Last First MI Maiden SSN

MAILING ADDRESS:

City State Zip

EMAIL ADDRESS:

TELEPHONE: Best time to call?

RADIOGRAPHY SCHOOL/COLLEGE INFORMATION

Radiography School Name:

City\ State Graduation Date:

Full Name of College Awarding Degree:

Type of Degree Awarded:

Date Degree Requirements were/will be met:

EDUCATIONAL INSTITUTIONS: List in chronological order (*Last being first*) all educational institutions you are currently attending and previously attended. An official transcript must be sent directly from each institution to: CARTI RT Program, P.O. Box 55050, Little Rock, AR 72215 and received by the first working day of March. Transcripts issued to students are not acceptable.

Name of Institution	Dates Attended	Degree\Certificate Earned

**CARTI RADIATION THERAPY PROGRAM
APPLICATION FOR ADMISSION**

Have you ever been convicted of a misdemeanor, felony, or a similar offense in a military court martial?

If you answer "Yes", provide an explanation of events relevant to the matter in the space below.

Yes _____ No _____

I am applying to CARTI Radiation Therapy Program. I hereby affirm that all information supplied on this form is complete and accurate. It is my understanding that I shall not be considered for interview until all required documents specified by this Program are received as identified on this application form. My eligibility will be determined based on the information I have provided. I understand that withholding information requested or giving false information will make me ineligible for participation in this program.

SIGNED

DATE