Date Received: _____

By: _____

APPLICATION FOR ADMISSION
Radiologic Technology Program
East Arkansas Community College
(870)633-4480, EXT. 270
(870)-633-7222 (FAX)

Please type or print.

Name: _____ _____ _____ _____
Last **First** **Middle** **Maiden**

Address: _____ _____ _____ _____
Street/P.O. Box **City** **State** **Zip**

Phone: _____ _____ _____
Home **Work** **Cell**

Student ID #: _____ **Email:** _____

Please indicate type of admission sought:

_____ **Initial Application** _____ **Readmission**

List all colleges/universities/technical schools attended. It is the student's responsibility to contact **all** of the institutions previously attended and request your OFFICIAL transcript be sent to **BOTH** the ***Office of the Registrar and Department of Allied Health Science – Radiologic Technology Program.*** Please use back of form, if more space is needed.

Note: Each transcript must be sent even if grades are recorded on another transcript. All transcripts must be mailed directly from the institution(s) to be considered official. All requested transcripts/information must be received by the application deadline.

College Dates attended

College Dates attended

College Dates attended

I certify that the above information is accurate. Applicants who misrepresent/omit information from the application form become ineligible for admission or subject to dismissal after admission has been granted.

SIGNATURE: _____ **DATE:** _____