Galveston College
4015 Avenue Q • Galveston, Texas 77550

ALLIED HEALTH PROGRAM APPLICATION

COMPUTED TOMOGRAPHY

Certificate Program

☐ CT-On-campus w/ clinic ☐ CT-On-campus w/o Clinic

☐ CT-Online w/Clinic ☐ CT-Online w/o Clinic

Date: _____ **Semester applying for** _____ **Year: 20_____**

Student ID: _____ **SS# (last 4 digits)**: _____ **DOB**: _____

Current place of Employment and position: _____
(If you want to complete clinical at your place of employment please complete Preferred Clinical location below.)

Graduating from (school/program: _____GPA: _____

Name: _____
Last First Middle/Other

Address: _____
Street and Apt. # E-mail Address

_____
City State Zip code

Phone: _____
Home Business Cell/Other

Do I need to locate a clinical location for you: ☐ Yes ☐ No

Preferred Clinical Location:

Hospital/Clinical Name:_____

Contact Name:_____ **Title**:_____

Contact Phone #:_____ **Contact E-mail**:_____

☐ I also understand that if I choose to participate in the Clinical portion that the Background Check and Drug Screen are to be my responsibility to complete prior to the start of the program at my expense.

Students
Signature_____Date_____

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