COLLEGE of CENTRAL FLORIDA
–an equal opportunity college–

ASSOCIATE DEGREE RADIOGRAPHY PROGRAM APPLICATION

The purpose of this application is to provide necessary personal data to comply with State and Federal regulations, and academic data to support your educational achievements. Please type or print clearly and complete the entire form. Submit application and documentation in person to the **Radiography Program, CF Ocala Campus Building 35, Room 104**, or by email to clarkes@cf.edu, during the application deadline stated in the online information packet and indicated on this application.

CF ID No.: _____

I have submitted the CF application and completed general admission requirements: ☐ Yes ☐ No

Date Radiography Information Session Completed: _____
Date: MM/DD/YYYY

Date Radiography Program Application Completed: _____
Date: MM/DD/YYYY

Legal Name: _____
Last First Middle (complete) Jr., etc.

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

County of Physical Address: _____

Mailing Address: _____
(if different from above) Street/P.O. Box City State Zip Code

Email: _____

Please note, due to federal radiation safety standards, the applicant must be 18 years of age by Aug. 1 of the year applying for enrollment.

Do you meet this requirement? ☐ Yes ☐ No

Radiography is a limited access program offered by the College of Central Florida. Limited access programs have admissions processes and criteria beyond general college admissions. While any student meeting the minimum criteria is encouraged to apply, not all applicants may be accepted.

SIGNATURE

By my signature below, I hereby certify that I am aware that the CF Radiography is a limited access program and federal radiation safety standards require that I am 18 years of age or older by Aug. 1 of the year applying for enrollment.

_____ _____
Signature Date: MM/DD/YYYY

List all colleges or schools attended, regardless of credit earned, including the College of Central Florida.

College	Dates Attended

SIGNATURE

By my signature below, I hereby certify that all of the information contained in this application is true and complete to the best of my knowledge. I understand that any misinterpretation or falsification of information is cause of denial of admission or expulsion from the college. I understand that illegal use, possession and/or misuse of any mind-altering substances are reasons for immediate dismissal from any programs in the Health Sciences Division. I understand that any arrests revealed on a criminal background check could be reason for denial of application or immediate dismissal from any program in the Health Sciences Division.

Signature _____ Date: MM/DD/YYYY _____

Radiography Program Application Deadline: June 23, 2023 by 4:30 p.m.

Have you attached all requested documents?

Have you made a copy of your application and supporting documents for your future reference and use?

For RTE office use only.

Date completed application received (MM/DD/YYYY): _____

Time received: _____ ☐ a.m. ☐ p.m.

Verifier Signature: _____