

REGISTRY PREP COURSE / REGISTRATION FORM

I am registering for the following course (check only one):

CT REGISTRY PREP COURSE

-10 weeks/sessions-
Tuesdays: 6:00PM to 9:00PM

CT 117

Begins: Feb 7, 2017
Ends: April 6, 2017

CT 217

Begins: June 2017
Ends: August 2017

CT 317

Begins: September 2017
Ends: December 2017

MRI REGISTRY PREP COURSE

-12 weeks/sessions-
Wednesdays: 6:00PM to 9:00PM

MRI 117

Begins: Feb 1, 2017
Ends: April 26, 2017

MRI 217

Begins: June 2017
Ends: September 2017

MRI 317

Begins: September 2017
Ends: December 2017

PERSONAL INFORMATION

DIRECTORY INFORMATION

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home (_____) _____ Work (_____) _____

Cell (_____) _____ Other (_____) _____

E-mail (required): _____ SS #: _____ - _____ - _____

DOB: _____ / _____ / _____ Male Female Place of Birth: _____

OCCUPATIONAL VERIFICATION

ARRT ID #: _____ NYS License #: _____

Please include a copy of both your ARRT Registration Card and your NYS license.

Are you a graduate of the Center for Allied Health Education? Yes No

If yes, which year did you graduate? : _____

(Center for Allied Health Education graduates may qualify for a Graduate Student Discount)

Where do you work? _____ In what position? _____

How did you hear about us? _____

Additional information regarding this course, along with tuition and fees, may be found on our website: www.cahe.edu

I certify that the information contained within this registration form is complete and accurate to the best of my knowledge and belief.

Signature of Applicant

Date

Mail this registration form with a \$100.00 (non-refundable) registration fee
(Payable to *New York Methodist Hospital*) by certified bank check or money order to:

**New York Methodist Hospital
Center for Allied Health Education
1401 Kings Highway
Brooklyn, NY 11229**

A registration form cannot be processed without receipt of the registration fee and a copy of your ARRT ID and NYS license cards.