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			MRI REGISTRY PREP COURSE -12 weeks/sessions- Wednesdays: 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 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.