



SwedishAmerican Mammography Application

Name (Last, first, MI): _____

Mailing Address (Street #/Apt #/PO Box): _____

City _____ State _____ Zip code _____

County of residence: _____ Date of Birth: _____

Telephone #: _____

Email Address: _____

Are you registered with the ARRT? Yes _____ ARRT# _____ No _____

Are you in good standing with the ARRT? Yes _____ No _____

Are you licensed with IEMA? Yes _____ IEMA# _____ No _____

If you answered no to any question, please explain:

How many years of experience do you have in radiography? _____

Current place of Employment: _____

Name of current Supervisor: _____

Telephone # of current supervisor: _____

May we contact them? _____

Signature: _____ Date: _____

Please e-mail this completed application to skgardner@swedishamerican.org