SwedishAmerican

Vascular Interventional

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:

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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