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Registration Form

Applying For

[ ] MRI Program [ ] CT Program [ ] Mammo Program [ ] Continuing Ed

Personal Data

Last Name: _____ First Name: _____ Middle Initial: ___

Address: _____ City: _____

State: _____ Zip Code: _____ Age:_____ Date of Birth: _____

Cell Phone: _____ E-mail Address: _____

Have you ever been convicted of a crime? Yes_____ No_____

If yes, state when, where and disposition case: _____

How did you heard about Us?

☐ Word of mouth. Who refer you? _____

☐ Advertising ☐ Online Searching

Application Fee

$150 (Non refundable if cancel by student)

Payment Method
[ ] Check or Money Order (enclose a check or money order payable to Imaging Educators).

[ ] Credit Card
[ ] Visa [ ] Master Card [ ] American Express [ ] Discovery

Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Exp Date: ____ / ____ CCV: __ __ __ Zip Code: __ __ __ __ __

By signing this application form I authorized Med Academy to debit the selected amount of $150.00 registration fee from my credit card.

Applicant Signature: _____ **Date: _____**