UNIVERSITY OF CINCINNATI ADVANCED MEDICAL IMAGING TECHNOLOGY PROGRAM

To the Applicant:

It is necessary that we request a statement of your general health and maintain such in our records. Please print your name in the appropriate space on the form below. Detach the form and have it signed by your physician, physician assistant, nurse practitioner, or other qualified healthcare provider. Return the form along with your application materials.

Note: This is not a request for a physical, only a statement concerning your general health.

University of Cincinnati
Advanced Medical Imaging Technology Program

_____

Applicant Name (please print)

I hereby authorize the individual named below to provide the requested information.

_____

Applicant Signature

To the best of my knowledge, the above named individual is in good physical and mental health and should be able to carry out the activities associated with obtaining diagnostic medical images in Magnetic Resonance Imaging, Nuclear Medicine Technology, and/or Computed Tomography.

_____

Printed Name (Physician, Physician Assistant, Nurse Practitioner, or other qualified healthcare provider)

_____

Signature

_____

Date

Return to applicant or directly to the AMIT Program to:
Fax - 513-558-4009
Email - AdvMedImaging@uc.edu