Crozer-Chester Medical Center
School of Clinical Neurophysiology
Application for Electroneurodiagnostic Technology Program

Non-Refundable Fee of $500.00 must be submitted upon official acceptance to the program.
**covers legal contracts for clinical experience

I wish to apply for application for the ☐ Seated Program

Name: _____
Last First Middle (Maiden)

Address: _____
Street

_____
City State Zip Code

Phone Number: _____ _____ _____
Home Cell Work

Social Security Number: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Email Address: _____

Education: (List high school, college and technical schools attended)

School Name	Location	Dates Attended	Graduated (Yes/No) If yes, list Major

Employment History:

Employer/Company	Location	Dates of Employment	Position(s) Held

Please answer the following questions and check the appropriate box:

Are you currently working in healthcare? ☐ Yes ☐ No

In what capacity? _____

Please feel free to contact the School of CNP with any questions at 610-447-2920/610-447-2691.

Statement of Application

I hereby apply for admission to the Crozer-Chester Medical Center, School of Clinical Neurophysiology, Neurodiagnostic Technology Program. I certify that the information contained in this application is true and complete to the best of my knowledge. I fully realize that omission or falsification will be sufficient reason for rejection of this application or dismissal from the program.

_____

Signature of Applicant Date

Print and complete the application, mail along with appropriate fees to:

School of Clinical Neurophysiology
Crozer-Chester Medical Center
2 West
One Medical Center Blvd
Upland, PA 19013

Phone: 610-447-2920 Fax: 610-447-2918