Imaging Certificate Program Clinical Request Form

Name: ________________________________  A#: ________________________________

City: ___________________________  State: _____  Phone #: ________________________________

Email address: ______________________________________________________________________

Preferred Clinical Site:
The clinical sites below are already affiliated with Chattanooga State. Please mark your 1st and 2nd choice. If these preferred sites are not close to you, please fill in the information under “Other” listed below.

Note: Space is limited for clinic site availability. You will be notified upon acceptance into the program.

☐ Erlanger
☐ Erlanger East
☐ Memorial
☐ Memorial Hixson
☐ Memorial Ooltewah Imaging
☐ Parkridge
☐ Parkridge East

Other: If you have a preferred clinic site and have contacted them, please give us this Information.

Name of Facility: _______________________________________________________________

Clinic Manager: _________________________________________________________________

Clinic Manager’s Phone Number: __________________________________________________

I certify that the above information is true and accurate to the best of my knowledge.

Student Signature ____________________________  Date _________________

Fax: 423-697-2628, mail or drop by:
Chattanooga State Community College
N&AH Application Coordinator, HSC 2088
4501 Amnicola Hwy
Chattanooga TN 37406