# STATE TECHNICAL COLLEGE

## MEDICAL RADIOLOGIC TECHNOLOGY PROGRAM

## ACT TEST WAIVER REQUEST

Applicant name: _____
(Please print)

Higher Education Institution from which degree was awarded:

_____

Degree awarded (BS, MS, AAS, etc.):

_____

Year degree was awarded: _____

Applicant Signature: _____

Date: _____

**Office use only:**

Received by: _____

Date entered: _____

Date application was submitted: _____