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: _____