

## UCD School of Medicine & Medical Science

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Date:

## PRE-CLINICAL HOURS DECLARATION FORM CT

Applicants Name	
Applicants Address	
Employment Address	
Mobile Phone Number	
E-mail Address	
Duration of Pre-course clinical experience	Number of days or weeks:
Scope of Pre-course clinical experience	<ul> <li>Type of CT scanner that you work on.</li> <li>Types of CT examinations observed or undertaken.</li> <li>Other CT experience.</li> </ul>
I confirm that the above named applicant has undertaken the requisite pre- course clinical experience in CT.	

**RSM or CSR Signature:**