

PERSONEL INFORMATION

APPLICATION FOR ADMISSION

Date of application _____

Name (Last, First, Middle Name)

Address (Number, Street, City, State, Zip Code)

Daytime phone _____ Social Security No. _____

Are you a citizen of the United States? Yes _____ No _____
(Appropriate documentation will be required upon acceptance into the program)

How did you learn about this program? _____

Please give a brief reason why you want to become a radiologic technologist:

EDUCATION

Type of School	Name and City/State	Courses Studied	Highest Grade Completed	Degree/Registration/Certification
High School				
College				
Graduate Work				
Other				

Send all transcripts from high school and college to the School of Radiography at the address above.

Describe any other training, courses of study, or skills related to radiology or patient care:

Related licenses or certifications:

EMPLOYMENT HISTORY

Start with your present or most recent job including military service assignments.

Employer _____ Job Title _____

Address _____

Telephone () _____ Start Date (mo./yr) _____ End Date (mo./yr)

Employer _____ Job Title _____

Address _____

Telephone () _____ Start Date (mo./yr) _____ End Date (mo./yr)

Employer _____ Job Title _____

Address _____

Telephone () _____ Start Date (mo./yr) _____ End Date (mo./yr)

REFERENCES

Provide three references from people who know you well and are not related to you (for example, former supervisor, principal, minister, teacher etc.) **You must contact these individuals and have them send a letter of recommendation to the school.**

1. _____
Name Title Phone

Address
2. _____
Name Title Phone

Address
3. _____
Name Title Phone

Address

APPLICATION CHECKLIST

You must do the following to be considered for the program:

1. Send all your high school and college transcripts
2. Send three letters of recommendations
3. Attend an observation day
4. Enclose a \$25 application fee
(make payable to Washington Adventist Hospital)

All materials must be sent to: School of Radiography, Washington Adventist Hospital, 7600 Carroll Avenue, Takoma Park, MD 20912

CERTIFICATION

I hereby certify that this application was completed by me and that all entries on it and information in it are true and complete to the best of my knowledge. I understand that false or misleading information given in this application and/or in my interview(s) will void this application or subject me to discharge at any time, if I am enrolled.

Applicant's signature _____ Date: _____