



Schools of Medical Imaging Application
(check program being applied for)

- Radiologic Technology
- Diagnostic Medical Sonography
- Echocardiography
- Computed Tomography Internship
- Magnetic Resonance Imaging Internship
- Interventional Procedures Internship

Please Type or Print

Application fee: \$25.00

LAST NAME	FIRST NAME	M.I.
FORMER NAMES (MAIDEN, FORMER MARRIED NAMES)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE
		ZIP CODE
()	()	
HOME TELEPHONE	CELL PHONE	EMAIL ADDRESS
GENDER: _____ MALE _____ FEMALE		CITIZENSHIP: _____ U.S.A. _____ OTHER
INTERNATIONAL STUDENT REQUIREMENTS: IS ENGLISH YOUR SECOND LANGUAGE: _____ YES _____ NO		
IF YES, PLEASE REFER TO INTERNATIONAL STUDENT POLICY		

Person to be notified in case of emergency:

NAME	RELATIONSHIP	PHONE NUMBER
STREET ADDRESS	CITY	STATE
		ZIP CODE

Please list each school attended and send official transcripts Attention: MEDICAL IMAGING PROGRAMS

HIGH SCHOOL	CITY	STATE	DATE GRADUATED
COLLEGE	CITY	STATE	DEGREE
COLLEGE	CITY	STATE	DEGREE
OTHER / RADIOLOGY PROGRAM (IF APPLICABLE)	CITY	STATE	COMPLETION DATE
A.R.R.T. ID NUMBER (IF APPLICABLE)	DATE	IF REGISTRY ELIGIBLE, DATE TEST WILL BE TAKEN	

ATTACH AN ADDITIONAL SHEET IF NEEDED

Employment History: Please list your last 3 places of employment.

EMPLOYER

JOB TITLE (RESPONSIBILITIES)

DATE OF EMPLOYMENT

References: Provide names of three individuals who are familiar with your work experience:

NAME

STREET ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

Have you ever been convicted of a crime? NO: _____ YES: _____ If yes, please see below

Certain convictions may disqualify an applicant from taking the National Certification Examinations as administered by the American Registry of Radiologic Technologist (ARRT) and the American Registry for Diagnostic Medical Sonographers (ARDMS) as established by their by-laws. Saint Luke's Hospital requires that all students must submit to a criminal background check, prior to admittance into the program. (Please see Certification Eligibility Statement)
<https://www.rrt.org/> or <http://www.ardms.org/>

Completion of required Job Shadow in Related Radiology field: Yes ___ No ___ Date _____

Institution _____ Number of hours _____

Write a brief paragraph explaining why you selected this field.

I understand that I must submit official transcripts from all schools, college or universities that I have attended. I certify that, to the best of my knowledge, all statements I have made in this application are complete and true. Failure to provide accurate information may result in denial of this application and/or dismissal from Saint Luke's Hospital Radiology Schools of Medical Imaging Programs.

SIGNATURE

DATE

Saint Luke's Hospital does not discriminate on the basis of sex, race, religion, age, color, handicap, sexual orientation, or national origin in the administration of its educational policies.

MAIL APPLICATION AND FEE (make payable to SCHOOLS OF MEDICAL IMAGING) TO:

**Saint Luke's Hospital Radiology Department
ATTN: School of Radiologic Technology 4401
Wornall Road, Kansas City, MO 64111**