Schools of Medical Imaging Application

(check program being applied for)

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

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 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.arrt.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.

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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 Health System
Attn: Diagnostic Medical Sonography Program
901 E 104th St.
Mailstop 3000 South
Kansas City, MO 64131