ArnotHealth

APPLICATION PROCEDURE

1. Complete your application form and submit with your $30 application fee payable to the Arnot School of Radiology. Cash will not be accepted.

2. With your application, submit your letter of intent answering the questions on the back of the application.

3. Submit an official copy of your high school transcript.

4. If applicable, submit an official copy of your GED including scores plus an official high school transcript.

5. Submit an official copy of college transcripts for **any** colleges you have ever attended.

6. Assure that all references have been submitted. Two references are required to be completed on the Arnot Ogden School of Radiologic Technology form. A guidance counselor, teacher or employer should complete these forms. The use of family members is not allowed.

7. The deadline for receipt of your application including your two reference forms and all transcripts is February 28th.

8. Mail your completed application, letter of intent, and your check or money order to:

Director
School of Radiologic Technology
St. Joseph's Hospital
555 St Joseph's Blvd
Elmira NY 14901

9. All applicants are required to present themselves for a personal interview with the Admissions Committee. You will be contacted, if you meet the minimum requirements for admission into the program, to schedule an interview.

10. If you have any questions, please contact Danielle Avery, Director of the School of Radiology, at (607)795-8040 Ext 2446 or email danielle.avery@arnothealth.org.

It is highly recommended that applicants schedule a shadowing experience with the school by calling Brenda Reynolds, Clinical Radiology School Coordinator *at (607) 737-4317 or brenda.reynolds@arnothealth.org. Shadowing will give an individual a better understanding of the radiology field.*

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ArnotHealth

Arnot School of Radiologic Technology

APPLICATION

Return forms promptly to: Director, School of Radiologic Technology, along with a $30 application fee.

NAME	_____ _____ *Last First Middle last 4 digits of Soc. Security No.*
LEGAL ADDRESS	_____ *Number and Street* _____ *City State Zip Code County* If your mailing address is different, give mailing address below: _____ *Number and Street City State Zip Code*
PERSONAL INFORMATION	Phone Number_____ Cell Phone Number _____ E-Mail Address_____ If you have education records under a different name, give former name: _____ Current high school students – please provide the following: Full name of guardian: _____ Address if different from yours: _____ _____ Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No If Yes, please explain _____ _____ *The previous conviction of a misdemeanor or felony does not automatically disqualify an applicant acceptance in to the program. However, it could affect an individual's right to be a certified licensed Radiologic Technologist. This should be discussed with the Director regarding the procedure to be followed to assure certification.*
SECONDARY EDUCATION	List all high schools or secondary schools attended. *Name of School City and State Diploma Received Dates* _____ _____
POST SECONDARY EDUCATION	List all formal education beyond high school. *Name of Institution City and State Major Credentials Earned/#Credits Dates* _____ _____ _____

Are you a U.S. citizen? ☐ Yes ☐ No

Have you ever attended a Radiologic Technology program? ☐ Yes ☐ No

If yes, provide school name and year attended_____

Have you previously applied for admission to this school? _____Date_____

EMPLOYMENT Employer's Name and Address: Employed from/to and reason for leaving.

_____

_____

_____

REFERENCES: Give the names and addresses of two persons who can give information about you**, <u>a teacher, counselor, or employer</u>.** The use of family members is not allowed.

Name_____ Position or Title _____

Address_____
(Number and Street) (City) (State) (Zip Code)

Name_____ Position or Title_____

Address_____
(Number and Street) (City) (State) (Zip Code)

_____

RESUME/LETTER OR INTENT: Submit a resume and a typewritten / double spaced essay which includes:

1) Your work experience and activities for the past 3 to 5 years.
2) Accomplishments that have given you the greatest satisfaction.
3) Reasons and research you have done for selecting radiologic technology as a career.
4) Reasons for desiring entrance into this school of radiologic technology.
5) Your plans for the future.

_____

DATE AND SIGNATURE: I hereby certify, that to the best of my knowledge, the information submitted in this application is complete and correct. I further understand that falsification of the information provided will result in cancellation of this application and dismissal from the program.

_____ _____
SIGNATURE *DATE*

YOUR NEXT STEP: Mail this application, $30 application fee, resume and essay directly to the Arnot Ogden Medical Center, School of Radiologic Technology. Request a transcript of high school and college grades be sent to <u>Arnot Ogden School of Radiologic Technology</u>. Two references completed on the Arnot Ogden School of Radiologic Technology form are also required. We will contact you regarding an interview appointment after all records have been received.

<u>Do not write below this line</u>

_____

To be completed after acceptance by School of Radiology
Person to be notified in case of emergency:

Name_____ Relationship_____

Address_____
(Number and Street) (City) (State) (Zip Code)

Home Telephone No._____ Business Telephone No._____

The School of Radiologic Technology does not discriminate on the basis of sex, race, national ethnic origin, age, religion, sexual preference, or handicapping conditions. If you have any questions concerning the above policy, please contact the Director, School of Radiologic Technology.

ArnotHealth

School of Radiologic Technology

This form should be completed by a guidance counselor, teacher or employer. The use of a family member is not allowed.

REFERENCE FORM #1

RECORDS ACCESS WAIVER

Unless this section is signed and dated by the candidate, the candidate has the right to review this letter of recommendation.

_____ _____

Date Signature

Directions to APPLICANT:

Please fill in your name. While it is not required, you may wish to execute the waiver of your right to review this evaluation. Whether you do or do not, this evaluation of you will remain confidential and will be restricted to only members of the Program's Admissions Committee.

Applicant's Name: _____

Your Name: _____ Date: _____

Length of time you have known the applicant: _____

Capacity in which you know the applicant: _____

Are you in any way related to the applicant ☐ Yes ☐ No

How do you feel this applicant would relate to working with ill patients? Explain:

_____

_____

_____

_____

How do you rate the applicant's ability to do college level work? Explain:

_____

_____

_____

_____

What do you consider to be the candidate's perceived weaknesses? _____

_____

_____

_____

_____

What do you consider to be the applicant's perceived strengths? _____

_____

_____

	Outstanding Top 10%	**Good Next Highest 15%**	**Average Middle 25%**	**Below Average Lowest 50%**	**Not Observed**
Motivation					
Sense of Responsibility					
Compassion					
Integrity					
Maturity					
Attention to Small Detail					
Cooperation					
Adaptability					
Oral Communication					
Written Communication					
Interpersonal Skills					
Reaction to Criticism					

Please comment on any Excellent or Below Average Rating given above:

General Comments regarding the applicant that you feel would be helpful to the Admissions Committee:

Please accept sincere thanks from the Arnot School of Radiologic Technology for your willingness in responding to this reference.

Please return this form as soon as possible to:

Director
School of Radiologic Technology
St. Joseph's Hospital
555 St Joseph's Blvd
Elmira NY 14901

ArnotHealth

Dr. Earl D. Smith
School of Radiologic Technology

This form should be completed by a guidance counselor, teacher or employer. The use of a family member is not allowed.

REFERENCE FORM #2

RECORDS ACCESS WAIVER

Unless this section is signed and dated by the candidate, the candidate has the right to review this letter of recommendation.

_____ _____
Date Signature

Directions to APPLICANT:

Please fill in your name. While it is not required, you may wish to execute the waiver of your right to review this evaluation. Whether you do or do not, this evaluation of you will remain confidential and will be restricted to only members of the Program's Admissions Committee.

Applicant's Name: _____

Your Name: _____ Date: _____

Length of time you have known the applicant: _____

Capacity in which you know the applicant: _____

Are you in any way related to the applicant ☐ Yes ☐ No

How do you feel this applicant would relate to working with ill patients? Explain:

_____

_____

_____

_____

How do you rate the applicant's ability to do college level work? Explain:

_____

_____

_____

_____

What do you consider to be the candidate's perceived weaknesses? _____

_____

_____

_____

_____

What do you consider to be the applicant's perceived strengths? _____

_____

_____

	Outstanding Top 10%	**Good Next Highest 15%**	**Average Middle 25%**	**Below Average Lowest 50%**	**Not Observed**
Motivation					
Sense of Responsibility					
Compassion					
Integrity					
Maturity					
Attention to Small Detail					
Cooperation					
Adaptability					
Oral Communication					
Written Communication					
Interpersonal Skills					
Reaction to Criticism					

Please comment on any Excellent or Below Average Rating given above:

General Comments regarding the applicant that you feel would be helpful to the Admissions Committee:

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