

Aultman Hospital School of Radiologic Technology Application Form

PERSONAL DATA

NAME: _____

SOCIAL SECURITY NUMBER: _____

PRESENT ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE NUMBER: _____

E-MAIL ADDRESS: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEAMENOR?

YES: _____

NO: _____

EDUCATION

GIVE NAMES AND COMPLETE ADDRESSES OF ALL SCHOOLS ATTENDED.

HIGH SCHOOL NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

DID YOU GRADUATE? YES: _____ NO: _____

COLLEGE NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

DID YOU GRADUATE? YES: _____ NO: _____

COLLEGE NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

DID YOU GRADUATE? YES: _____ NO: _____

We accept applications on a year-round basis. However, the application deadline is Feb.1 if you wish to be considered for the program beginning in August.

PROFESSIONAL LICENCES, REGISTRATIONS, AND/OR CERTIFICATIONS

TYPE: _____ DATE: _____ NO. _____

TYPE: _____ DATE: _____ NO. _____

EMPLOYMENT

LIST ALL EMPLOYMENT AND REASONS FOR LEAVING. START WITH YOUR MOST RECENT EMPLOYMENT.

FROM MO YR.	TO MO YR.	EMPLOYER	SUPERVISOR	POSITION
		ADDRESS	PHONE	SALARY
		CITY, STATE, ZIP		

FROM MO YR.	TO MO YR.	EMPLOYER	SUPERVISOR	POSITION
		ADDRESS	PHONE	SALARY
		CITY, STATE, ZIP		

FROM MO YR.	TO MO YR.	EMPLOYER	SUPERVISOR	POSITION
		ADDRESS	PHONE	SALARY
		CITY, STATE, ZIP		

CERTIFICATION STATEMENT

I HEARBY CERIFY THAT THE ANSWERS TO ALL THE QUESTIONS AND STATEMENTS IN THIS APPLICATION ARE CORRECT. I UNDERSTAND THAT ANY FALSE STATEMENTS, MISINTERPRETATIONS, OR OMISSIONS MAY BE CAUSE FOR IMMEDIATE DISMISSAL. I AUTHORIZE THE COMPANIES, SCHOOLS, OR ANY PERSON HAVING KNOWLEDGE OF, TO GIVE INFORMATION REGARDING MY EMPLOYMENT OF EDUCATION TO AULTMAN HOSPITAL SCHOOLS OF RADIOLOGY EDUCATION.

SIGNATURE

DATE

THE AULTMAN HOSPITAL POLICY OF EQUAL OPPORTUNITY IS TO PROTECT THE HUMAN RIGHTS OF ALL EMPLOYEES, STUDENTS, APPLICANTS, AND PATIENTS. OUR CONTINUING PLAN OF AFFIRMATIVE ACTION SEES TO IT THAT NO PERSON WILL BE DENIED OR GIVEN ADVANTAGE, FACILITY, PRIVILEGE, OR BE DISCRIMINATED AGAINST IN ANY WAY BECAUSE OF RACE, RELIGION, NATIONAL ORIGIN, DISABILITY, AGE, ANCESTRY, SEX, OR VETERAN STATUS.

Please mail the completed form to:

Linda Celik
Aultman Hospital School of Nursing
2600 Sixth St., S.W.
Canton, OH 44710