

Aultman Hospital School of Radiologic Technology Application Form

NOTE: A \$30 application fee must be submitted with your application.

PERSONAL DATA

NAME: _____

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 CERTIFY THAT THE ANSWERS TO ALL THE QUESTIONS AND STATEMENTS IN THIS APPLICATION ARE CORRECT. I UNDERSATND THAT ANY FALSE STATEMENTS, MISINTERPRETATIONS, OR OMISSIONS MAY BE CAUSE FOR IMMEDIAITE DISSMISAL. I AUTHORIZE THE COMPANIES, SCHOOLS, OR ANY PERSON HAVING KNOWLEDGE OF, TO GIVE INFORMATION REGARDING MY EMPLOYMENT OR 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, STUDENT S, APPLICANTS, AND PATIENTS. OUR CONTINUING PLAN OF AFFIRMATIVE ACTION SEES TO IT THAT NO PERSON WILL BE DENIED OR GIVEN ADVANTAGE, FACILITY, PRIVELEGE, 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:

**Michelle Speedy
Aultman College of Nursing and Health Sciences
2600 Sixth St., S.W.
Canton, OH 44710**

**AULTMAN HOSPITAL
SCHOOL OF RADIOLOGIC TECHNOLOGY REFERENCE LETTER**

Name of Applicant _____

Is applying to the Aultman Hospital School of Radiologic Technology.

We would appreciate if you would take a moment to answer some questions about this individual. The purpose is to help us evaluate this applicant's suitability for our educational program. All comments will be held in **strictest confidence**. Thank you!

1. How long have you known this person? Dates: _____

2. In what capacity do you know this individual?

For the following items, please rank the applicant (1= lowest/poor, 5= highest/excellent)

- | | |
|----------------------------|-------------------------------------|
| _____ work habits | _____ interpersonal skills |
| _____ study habits | _____ honesty |
| _____ attendance | _____ compassion |
| _____ attitude | _____ ability to follow instruction |
| _____ work quality | _____ ability to accept criticism |
| _____ work quantity | _____ integrity |
| _____ communication skills | _____ empathy for others |

Additional Comments: _____

Signature: _____ Date: _____

Position: _____

Address: _____

Phone: _____ E-mail address: _____

Please mail the completed form to:

**Michelle Speedy
Aultman College of Nursing and Health Sciences
2600 Sixth St., S.W.
Canton, OH 44710**