MedStar Washington
Hospital Center

Medical Imaging School of Radiography

2014 Application

www.medstarwashington.org/medicalimaging

WASHINGTON HOSPITAL CENTER
X-RAY
19 60
SCHOOL OF RADIOLOGY

Submit

APPLICATION INSTRUCTIONS

Clear Form

Submit completed application, official transcripts from college *(include SAT scores)* and a two page typed autobiography directly to the program. The autobiography should include information that will support your application to the program. International students will be required to demonstrate English language competancy. All documentation must be submitted by June 30th, of the year to be considered. Please call one month after submitting this application for an update on your application status.

Submit the application, transcripts and autobiography to:

MedStar Washington Hospital Center
Medical Imaging School
Radiology Department
East Building, Room GO35
110 Irving Street, NW
Washington, DC 20010-2976

Attn: **Mitchell Bieber, MSHCA, RT(R)**

Send a $25 nonrefundable check *(cash not accepted)* for the application fee, made payable to MedStar Washington Hospital Center to:

Attn: **Shana Reams**
MedStar Washington Hospital Center
Imaging Reimbursement Manager
Radiology Rm BA-80
110 Irving Street, NW
Washington, DC 20010-2976

NON-DISCRIMINATION STATEMENT MedStar Washington Hospital Center, a private, not-for-profit hospital, does not disciminate on grounds of race, religion, color, gender, physical hendicap, national origin or sexual preference. The hospital center is an equal opportunity employer.

DISCLAIMER The provisions of this brochure/application are not to be regarded as an irrevocable contract between the student and the Washington Hospital Center. The Hospital Center reserves the right to change any provision or requirement at any time within the student's term of enrollment. Any changes will be made known to the student through periodic updates.

CERTIFICATION I hereby certify that the information given in this application form is true and complete to the best of my knowledge. You are authorized to conduct investigations, including verification of prior education and employment history. I also understand that acceptance into the program is dependent upon satisfactory completion of a background check and health screening, which will include illicit drug or alcohol testing. False statements are grounds for disqualification.

SIGNATURE OF APPLICANT DATE

MedStar Washington
Hospital Center

MEDSTAR WASHINGTON HOSPITAL CENTER

Medical Imaging School of Radiography

APPLICATION FORM

All applications, original transcripts and supporting documentation must be submitted by June 30, 2014 in order to be considered. The class will commence on September 8, 2014.

Please print clearly, or type. Do not leave blank spaces. Write/type "N/A" if information is not applicable to you.

Name	Date
Previous name (s):	
Address	Apt. #
City/State/Zip	
Home phone	Work phone
Cell phone	E-mail
Social Security number	
Are you a U.S. citizen? ☐ Yes ☐ No	
If no, please give current residency status:	

Contact person in case of emergency: Name:	
Phone number:	Cell:

Have you ever been convicted of a felony? ☐ Yes ☐ No
Please note: A felony conviction may disqualify you from taking the national examination given by the American Registry of Radiologic Technologists (ARRT)
Have you ever applied to this program before? ☐ Yes ☐ No
If yes, what year(s)?:

EDUCATION AND TRAINING

High School Attended		
Name:		
Location:		
Dates attended:	from:	to:
Date of Graduation:		

College, Universities or Technical Schools Attended		
Name:		
Location:		
Dates attended:	from:	to:
Degree or credit hours:		
Major:		
Name:		
Location:		
Dates attended:	from:	to:
Degree or credit hours:		
Major:		
Name:		
Location:		
Dates attended:	from:	to:
Degree or credit hours:		
Major:		
Name:		
Location:		
Dates attended:	from:	to:
Degree or credit hours:		
Major:		

If you hold any licenses or registration related to medical, dental, allied health or veterinary medicine, please list them below and provide original documentation	
Organization:	Number:
Organization:	Number:
Organization:	Number:

If you have completed any CPR or first aid training, please list below and attach a copy of your card
1.
2.

WORK AND VOLUNTEER EXPERIENCE

Since admission decisions are based on a scoring system that awards points for prior patient care experience, it is important that you give us a complete record of work or volunteer experience, especially if it includes experience in a hospital, medical office, dental office ot veterinary clinic. Please include a reference.

Start with your present or most recent experience	
Time employed from:	to:
Name of employer:	
Job title:	
Responsibilities:	
Reference name:	Phone number:
Was this a paid position? ☐ Yes ☐ No	
Time employed from:	to:
Name of employer:	
Job title:	
Responsibilities:	
Reference name:	Phone number:
Was this a paid position? ☐ Yes ☐ No	
Time employed from:	to:
Name of employer:	
Job title:	
Responsibilities:	
Reference name:	Phone number:
Was this a paid position? ☐ Yes ☐ No	

List 3 professional references:		
Reference Name	Address	Phone Number
1		
2		
3		

Paste Auto Biography Here