Medical Radiography Program
Winchester Medical Center

Name_____ _____
Last First Middle ALL other last names used

Address_____

City_____State_____Zip _____

(Please check the location where you are most likely to be reached between the hours of 8am – 5pm)

Telephone ❒Home ( )_____❒Business ( ) _____

Email Address_____❒Cell ( )_____

Social Security Number _____

Have you ever applied for admission to one of Winchester Medical Center's educational programs?
If yes, which one and when? _____

How did you become aware of this program? Self____Newspaper_____Employee_____Counselor_____Other_____
VHS Jobline____VHS Website_____Open House_____Career Day____

In case of emergency, notify_____Relationship _____

Address_____Phone ( ) _____

City_____State_____Zip_____

Education

Are you a high school graduate? Senior_____Yes_____ GED? Yes_____No _____

Name and address of high school attended _____

Other schools attended (vocational, computer training, etc; circle number of years completed) 1 2 3

Name and address of college, vocational school, etc. _____

_____

Please specify any degrees or diplomas earned _____

_____

NOTE: College transcripts must be mailed to the Medical Radiography Program, 220 Campus Boulevard, Suite 300, Winchester, Virginia, 22601 from the institution(s) attended in an envelope sealed by the institution's registrar or may be emailed to WMCRadProgram@valleyhealthlink.com Your application fee of $25.00 and aptitude testing fee of $85.00 is also required to be submitted with your application.

Phone: 540-536-7935

Please continue on back

Previous Employment

Begin with your current or most recent employment (include military service).
Please list <u>ALL</u> employment.

1. Place of employment_____Final salary _____
Address _____ City_____State _____ Zip_____

Employed from_____to_____Supervisor's name_____Phone ( ) _____
Your position_____Reasons for leaving _____

2. Place of employment_____Final salary _____
Address_____City_____ State_____Zip _____
Employed from_____to_____Supervisor's name_____Phone ( ) _____
Your position_____Reasons for leaving _____

3. Place of employment_____Final salary _____
Address_____City_____State_____Zip _____
Employed from_____to_____Supervisor's name_____Phone ( ) _____
Your position_____Reasons for leaving _____

May we contact the employers listed above for references purposes?_____Yes_____No

Please indicate by the appropriate number(s) any we should not contact and why _____

Have you ever been discharged or asked to resign from a job?_____Yes_____No
If yes, please explain _____

Have you ever been convicted of a felony?_____Yes_____No
If yes, please contact *The American Registry of Radiologic Technologists* at 651-687-0048.

Describe any course work, skills, or volunteer experience you have had that is relevant to this application.

Why do you want to enter this program? What are your goals?

By my signature below, I certify that I have read this application. I have not withheld any requested information and the responses on this application are true to the best of my knowledge. I understand that any falsification or misrepresentation may be cause for rejection of this application.

_____ _____
Signature of Applicant Date

<u>Application Deadline is October 31 of Each Year</u>

Please send to the Medical Radiography Program, 220 Campus Blvd, Ste. 300, Winchester, Virginia, 22601or
WMCRadProgram@valleyhealthlink.com