Winchester Medical Center School of Medical Imaging
Computed Tomography Program Application

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 ___ Employee ___ Counselor ___ VHS Website_____

In case of emergency, notify _____ Relationship _____

Address _____ Phone ( ) _____

City _____ State _____ Zip_____

Education

ARRT Primary Discipline (please check the discipline you currently hold certification and registration in)

❒ Radiography ❒ Nuclear Medicine Technology ❒ Radiation Therapy

School attended where primary discipline certification or degree was earned (please include address).

ARRT ID#_____

Please provide a copy of your current ARRT card to the Winchester Medical Center School of Medical Imaging.

NOTE: ARRT card copies must be delivered to the Winchester Medical Center School of Medical Imaging, 220 Campus Boulevard, Suite 300, Winchester, Virginia, 22601. Your application fee of $25.00 is also required to be submitted at this time along 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_____
Address _____ City_____ State _____ Zip_____
Employed from _____ to _____ Supervisor's name _____ Phone ( ) _____
Your position _____Reasons for leaving _____

2. Place of employment _____ Address
_____ City _____ State _____ Zip _____
Employed from _____ to _____ Supervisor's name _____ Phone ( ) _____
Your position _____ Reasons for leaving _____

3. Place of employment _____
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 _____

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 November 15 or May 15</u>

Please send to the Winchester Medical Center School of Medical Imaging, 220 Campus Blvd, Ste. 300, Winchester, Virginia, 22601