ValleyHealth
Winchester Medical Center

MEDICAL RADIOGRAPHY PROGRAM

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 8 a.m. - 5 p.m.)
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 _____ VHS Website ___ Employee ___ Counselor ___ Other ___

In case of emergency, notify _____ Relationship _____

Address _____ Phone (_____) _____

City _____ State _____ Zip _____

EDUCATION Applicants MUST possess an associate's degree or be within 8 credits of completion at the time of beginning the radiography program.

☐Associate's Degree and or credentials earned: *(You MUST provide a copy of your official sealed transcripts)*

Degree Type: _____ **School/Location:**_____

NOTE: All college transcripts must be delivered to the Medical Radiography Program, 220 Campus Boulevard, Suite 300, Winchester, VA, 22601 from the institution(s) attended in an envelope sealed by the institution's registrar. Your $25 application fee and $85 aptitude testing fee are required to be submitted when you arrive for testing. Checks payable to WMC School of Medical Imaging. Phone: 540-536-7935

PREVIOUS EMPLOYMENT

Begin with your current or most recent employment (include military service)

Please list last 3 areas of employment.

1. Place of employment_____
   Address_____ City _____ State_____ Zip _____

   Employed from _ to Supervisor's name _ Phone ( ) _

   Position held_____ Reason for leaving _____

2. Place of employment_____
   Address_____ City _____ State_____ Zip _____

   Employed from _ to Supervisor's name _ Phone ( ) _____

   Position held_____ Reason for leaving _____

3. Place of employment_____
   Address_____ City _____ State_____ Zip _____

   Employed from _ to Supervisor's name _ Phone ( ) _

   Position held_____ Reason 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