United Hospital Center

Diagnostic Medical Sonography Program

327 Medical Park Drive Bridgeport, WV 26330

APPLICATION

Last	First	M.I.
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Have you previously applied to this or another sonography training program? Yes No If yes, please list the school(s) and tell when you applied.		

EDUCATION		
School	Attendance Dates	Credits or Diploma / Certificate
High School Name: City/State:		
College Name: City/State:		
College Name: City/State:		
Other Name: City/State:		

It is the policy of United Hospital Center Diagnostic Training Programs to provide equal opportunity to prospective and current students solely on the basis of individual quality and merit, without regard to race, religion, age, sex, national origin, or disability and in full compliance with all federal and state laws.

Complete all present and past employment, beginning with your most recent. If necessary attach resume.

Name of Company / Institution	Position Held	From Mo/Yr	To Mo/Yr	Reason for Leaving
Address				
Telephone	Name of Supervisor			
Briefly summarize experience gained, including any special training you received:				
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Address				
Telephone	Name of Supervisor			
Briefly summarize experience gained, including any special training you received:				

Describe any healthcare-related volunteer experience, including the length of time spent in the position and the name(s) and phone number(s) of supervisory personnel.

Name of Company/ Institution	From/To	Description of activity
Name of Supervisor	Telephone	
Name of Company / Institution	From/To	Description of activity
Name of Supervisor	Telephone	

I authorize investigation of all statements contained in this application. I certify that all of my answers and statements are true. It is understood and agreed that any misrepresentation by me in this application will be sufficient cause for cancellation of the application. It is understood that acceptance of the program is subject to a satisfactory examination by a physician designated by United Hospital Center. I voluntarily give United Hospital Center permission to make a thorough investigation of my past employments and all other facts stated above, and release from all liability or responsibility all persons supplying information.

_____ _____

Signature Date