# United Hospital Center

**Radiologic Technology 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 been convicted of a crime including a felony, gross misdemeanor or misdemeanor other than speeding and parking violations? No Yes (If yes, explain)

(All alcohol or drug-related violations must be reported.)

Do you have any physical, mental or medical impairment or disability that would limit your ability to meet the Admissions Criteria/Technical Standards as published on the UHC website (www.uhcwv.org)? No Yes (If yes, explain)

Have you previously applied to this or another diagnostic training program? No Yes
If yes, please list the school(s) and tell when you applied.

## EDUCATION

| School | Course of Study | Years/ Credits completed | Diploma / Certificate Awarded with Date |
|---|---|---|---|
| <u>High School</u><br>Name:<br>City/State: | | | |
| <u>College</u><br>Name:<br>City/State: | | | |
| <u>Other</u><br>Name:<br>City/State: | | | |

It is the policy of United Hospital Center Diagnostic Training Programs to use student recruitment and admission practices that are non-discriminatory with respect to any legally protected status such as race, color, religion, gender, age, disability and national origin.

***OVER***

**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:

| **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:

**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 activities |
|---|---|---|
| Name of Supervisor | Telephone | |

## PERSONAL REFERENCES

(Do not list former employers or relatives)

| **Name** | **Street Address** | **City** | **State, Zip** | **Telephone** |
|---|---|---|---|---|
| 1.(Mr./Mrs./Ms.) | | | | |
| 2.(Mr./Mrs./Ms.) | | | | |

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