

RADIOLOGIC TECHNOLOGY PROGRAM APPLICATION

Pierpont Community and Technical College
School of Health Careers

I am applying to: **United Hospital Center** _____ **West Virginia University Hospitals** _____ **Both** _____

Admission to the Radiologic Technology Program will be contingent upon your score on the score sheet, criminal background investigation and your health status. The application deadline is **January 31** for the class beginning in July. **All required documentation (see below), including the non-refundable \$20 application fee, must be received by the deadline.** In order to facilitate the processing of your application, please submit all documents to:

Pierpont Community & Technical College
ATTN: Enrollment Services
1201 Locust Avenue
Fairmont, WV 26554

Before your application will be reviewed, **all documents relating to admission must be on file.** The following must be received:

- General Admission Application
- Official High School Transcript/GED Scores
- Official Transcript(s) from all colleges/universities attended
- Course Placement Scores (ACT/SAT)
- Program Application
- Non-refundable program application fee of \$20
 - Please do not send cash
 - Make checks payable to 'Pierpont Community & Technical College'

Name:		
Street Address:		
City:	State:	Zip:
Phone:	Student ID Number:	
Do you have any physical, mental or medical impairment disabilities that would limit your ability to participate in this program? 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	Level Attained	Credits or Diploma / Certificate
<u>High School</u>			
Name:			
City/State:			
<u>College</u>			
Name:			
City/State:			
<u>Other</u>			
Name:			
City/State:			

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

Name of Company / Institution	Position Held	From / To		Reason for Leaving
		Mo/Yr	Mo/Yr	
Address				
Telephone	Name of Supervisor			

Briefly summarize experience gained, including any special training you received.

Name of Company / Institution	Position Held	From / To		Reason for Leaving
		Mo/Yr	Mo/Yr	
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	

PERSONAL REFERENCES

(Do not list former employers or relatives)

Name	Street Address	City	State, Zip	Telephone
1.				
2.				
3.				

It is the policy of the United Hospital Center Diagnostic Training Program and/or West Virginia University Hospitals 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.

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 into the program is subject to a satisfactory examination by a physician designated by United Hospital Center and/or West Virginia University Hospitals. I voluntarily give United Hospital Center and/or West Virginia University Hospitals 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