WVU Medicine
UNITED HOSPITAL CENTER

# Radiologic Technology Program Application

**327 Medical Park Drive Bridgeport, WV 26330**

Admission to UHC Radiologic Technology Program is contingent upon points earned following evaluation of your academic transcripts, a personal interview, Criminal Background Investigation results and overall health status. Applications and records must be mailed to the above address and postmarked by March 1st for the class beginning in August. **Required documents including a completed application, high school transcript, ACT or SAT test scores, and transcripts from all postsecondary education must meet the postmarking deadline of March 1st.**

| Last | First | Middle Name |
|---|---|---|
| Name: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Primary Phone: | ( mobile / landline ) | Last 4 digits of SS#: |
| Email Address: | | |
| Have you previously applied to this or another radiologic technology training program? No Yes<br>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