Saint Joseph Health System
Radiography Program

# ADMISSION APPLICATION

Saint Joseph Health System Radiography Program is dedicated to providing a quality education for individuals in the field of radiologic technology. The program incorporates the core values of Catholic Health Initiatives, which includes reverence, integrity, compassion and excellence. Our mission is to produce competent technologists for the various aspects of the profession.

## PLEASE PRINT OR TYPE INFORMATION SUBMITTED

Full Legal Name: _____
First Middle Last

Address: _____

_____
City State Zip Code

Social Security Number: _____

Phone Number: ( ) _____ Birth Date: _____
month/date/year

College Attended: _____

College Address: _____

_____
City State Zip Code

College Attended: _____

College Address: _____

_____
City State Zip Code

Does applicant have educational records in a different name? ____ Yes ____No

Date of College Graduation: Month _____ Year _____

Date of High School Graduation: Month _____ Year _____

GED recipients - Date GED completed: Month _____ Year _____

- over -

Have you applied to the SJHS Radiography Program before? ___Yes ___ No
If yes, please provide the year of application:

_____

Please provide the names, addresses and phone numbers of two people as references (Not Relatives):

Name: _____

Address: _____

_____
City State Zip Code

Name: _____

Address: _____

_____
City State Zip Code

I hereby affirm that all information supplied in the application is complete and accurate.
I understand that withholding information or giving false information will make me ineligible for program admission.

_____ _____
Applicant's Signature Date

Saint Joseph Health System Radiography Program is an equal opportunity educational institution.