



SCHOOL OF

Diagnostic Medical Sonography

WYOMING VALLEY
HEALTH CARE SYSTEM

School of Diagnostic Medical Sonography
575 North River Street • Wilkes-Barre, PA 18764-0001
570-552-4654

APPLICATION FOR ADMISSION

NAME _____
last first middle maiden name

ADDRESS _____
street city state zip code

EMAIL ADDRESS _____

TELEPHONE _____ **SS #** _____ **DOB** _____

Acceptance for this Program is subject to establishing identity and authorization to study in the US.

Are you a U.S. Citizen or Alien who has the legal right to remain and be educated in the USA? Yes No
(you will be required to provide documentation proving eligibility)

Have you ever been convicted of a crime, excluding those convictions which have been annulled, expunged or sealed by the Court? Yes No (conviction will not necessarily disqualify an applicant from enrollment)

EDUCATION

NAME & LOCATION	YEARS ATTENDED	DEGREE/DIPLOMA
High School _____		
College _____		
Allied Health _____		

TRANSCRIPTS MUST BE INCLUDED FROM ALLIED HEALTH AND/OR COLLEGE ALONG WITH ATTENDANCE RECORDS. APPLICANTS ARE RESPONSIBLE FOR SUBMITTING TRANSCRIPTS ON TIME.

EMPLOYMENT (LIST MOST RECENT EMPLOYER FIRST)

NAME AND ADDRESS	TYPE OF BUSINESS	DATES/FROM-TO	POSITION HELD	REASON FOR LEAVING

Comments: _____

LETTERS OF REFERENCE

REFER TO COVER LETTER FOR REQUIRED REFERENCES. THREE LETTERS OF REFERENCE IN SEALED ENVELOPES MUST ACCOMPANY THIS APPLICATION.

REFERENCE

POSITION/ASSOCIATION

LETTER OF INTENT/APPLICANT ESSAY

Please provide a 2-page (maximum) typed letter indicating your reasons for pursuing the diagnostic medical sonography profession. Within the letter, please elaborate on your perspectives of the profession in addition to your strengths in communication skills, patient care and independent critical thinking skills.

APPLICATION FEE

Application fee of \$10.00 must accompany this application.
Check or money order may be made payable to Wyoming Valley Health Care System.

STATEMENT OF VERACITY

The facts set forth in my application for enrollment are true and complete.

I hereby authorize investigation of all statements contained in this application for enrollment and/or any other document completed by me in connection with my enrollment; I permit a detailed employment check including but not limited to a check with previous employers, criminal background check service, criminal background investigation, Criminal History Check, Child Protective Agencies Check, etc. and/or Division of Motor Vehicles Record Check. I release Wyoming Valley Health Care System from any and all liability from such investigation. I understand that any false statement, misrepresentation or omission of facts from this application may cause for immediate dismissal. I further agree to undergo a pre-placement physical examination and any additional physical examinations that may be required in connection to my continued enrollment. Also, I hereby give my consent to such physicians to report their findings to the School.

I hereby attest that I am not currently nor do I anticipate designation as an Excluded Individual as determined by the HHS/OIG and/or GSA. Additionally, I will disclose such designation immediately to WVHCS should I have or attain status as an Excluded Individual as determined by the HHS/OIG and/or GSA.

SIGNATURE

DATE

Please send your completed application – along with your letters of reference, documentation of observation, letter of intent/applicant essay and application fee to:

WYOMING VALLEY HEALTH CARE SYSTEM
SCHOOL OF DIAGNOSTIC MEDICAL SONOGRAPHY
ATTN. LISA CAPIZZI
WILKES-BARRE GENERAL HOSPITAL • 575 NORTH RIVER STREET • WILKES-BARRE, PA 18764-0001