



SCHOOL OF Radiography

WYOMING VALLEY
HEALTH CARE SYSTEM

**Wilkes-Barre General Hospital
School of Radiography**
575 North River Street • Wilkes-Barre, PA 18764-0001
570-552-1760 • Fax 570-552-2476

APPLICATION FOR ADMISSION

(Please print or type information)

NAME _____
last first middle maiden name

ADDRESS _____
street city state zip code

EMAIL ADDRESS _____

TELEPHONE _____ **SS #** _____

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)*

MILITARY SERVICE

Did you ever serve in the armed forces? Yes No

Branch _____ Discharge Date _____

Member of the Reserves? Yes No Status: Active Inactive

EDUCATION

NAME & LOCATION	YEARS ATTENDED	DEGREE/DIPLOMA
HIGH SCHOOL _____		
COLLEGE _____		
OTHER _____		

High school transcripts are required. Transcripts must include SAT Scores and attendance.
Applicants are responsible for submitting transcripts on time.

EMPLOYMENT

(LIST MOST RECENT EMPLOYER FIRST)

NAME & ADDRESS OF EMPLOYER	TYPE OF BUSINESS	EMPLOYED FROM	TO	POSITION HELD	REASON FOR LEAVING
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LETTERS OF REFERENCE

* Refer to cover letter for **required** references. Three letters of reference in sealed envelopes must accompany this application. *If you are out of school over 10 years, employers, supervisors, mentors, etc. may be used in place of instructors.*

<u>REFERENCE</u>	<u>POSITION/ASSOCIATION</u>
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LETTER OF INTENT

On a separate sheet, please indicate your reasons for pursuing a career in radiography and your goals for the future. Please discuss what you have researched to be the **advantages & disadvantages** of the profession. Include it with this application.

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

DATE

APPLICATION FEE

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

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**