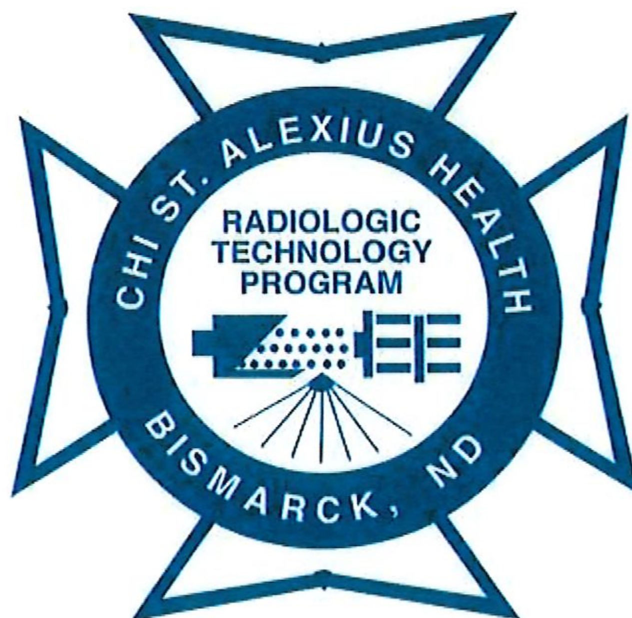
APPLICATION
FOR
CHI ST. ALEXIUS HEALTH/
UNIVERSITY OF MARY
RADIOLOGIC TECHNOLOGY PROGRAM



Dear Applicant:

We would like to thank you for your interest in obtaining your professional education in Radiologic Technology at CHI St. Alexius Health. As you are aware, we offer a two year internship program in Radiologic Technology and are cosponsored by the University of Mary.

The admission procedure includes the completion of this application packet. To be sure that you have completed/included all necessary items for your application, the following listing should be helpful in double-checking your packet:

- application form
- high school transcripts
- current college transcripts - January 1
- ACT results
- three personal references
- reference release form
- $25.00 application/processing fee

The deadline for acceptance of applications by the program is December 15 of each year. All applicants will be notified whether or not they have been selected for a personal interview.

Good luck in pursuing your education in Radiologic Technology.

APPLICATION FOR ADMISSION

(Please include a $25.00 non-refundable application fee.)

CHI St. Alexius Health/University of Mary
Radiologic Technology Program
900 East Broadway Avenue
Bismarck, ND 58501
(701) 530-7726

Application Date: ____________________ Date Application Received (**Office Use**) ____________________

Please request that college transcripts be sent to the above address.

Name (Print): ________________________ ________________________ ______
Last First MI

Current Address: ____
Street, City, State, Zip Code

Permanent Address: ____
Street, City, State, Zip Code

Telephone Number: ________________________ ________________________
Home Cell

Social Security #: ________________________ Date of Birth (Optional): ____________________

E-Mail Address: ____

Do you currently hold a college degree? Yes ____ No ____

If yes, please list type of degree and major: ____

Have you ever been convicted of a felony? Yes ____ No ____

PERSON TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY:

Name: ________________________________ Telephone Number: ____________________

Address: ____
Street, City, State, Zip Code

PREVIOUS EDUCATION

High School(s): ____
Name of School, City, State

____
Name of School, City, State

High School Graduation Date: ____________________

COLLEGES OR UNIVERSITIES ATTENDED:

______________________ ______________ ____________________
Name Dates Attended Grad. Date/Degree Earned

______________________ ______________ ____________________
Name Dates Attended Grad. Date/Degree Earned

______________________ ______________ ____________________
Name Dates Attended Grad. Date/Degree Earned

PERSONAL INFORMATION

Please attach a typewritten sheet(s) with the following information included:

1) List extracurricular activities and/or organizations in which you have participated as a student. Include elected or leadership positions.
2) Things you have accomplished that have given you the greatest satisfaction
3) Your reasons for selecting Radiologic Technology as a career.
4) Reasons (if any) for your desire to enter this Program.
5) Your long-term goals/plans.
6) Work experience: include employer, dates of employment, major responsibilities. List the most recent experience first.

REFERENCES:

Using the three included reference forms, please give these to persons able to objectively comment on your academic strengths and personal qualities. **Please exclude personal friends and relatives.** Instruct your references to return the completed form to you in a sealed envelope. If this is not feasible, they may return it to the Program directly.

PERSONAL REFERENCE FORM
CHI ST. ALEXIUS HEALTH/UNIVERSITY OF MARY
RADIOLOGIC TECHNOLOGY PROGRAM

APPLICANT'S NAME: ____

TO THE APPLICANT: Students of the Radiologic Technology Program have the right to inspect their files upon request. So that the person you have requested to write a letter of recommendation will know their letter will be held in confidence or if the letter will be open to inspection, the following policy is stated:

"Letters of recommendation are destroyed at the time program selections are made and prior to the applicant becoming an official Radiologic Technology Program student. Therefore, **the applicant will never see these letters**. This policy assures the person writing the recommendation that this letter will remain confidential."

TO THE EVALUATOR: The above person is applying for admission into the above mentioned Radiologic Technology Program.

Personal recommendations are a very important part of the application. Each recommendation is reviewed by members of the Selection Committee. We attempt to select those individuals whose accomplishments, personal attributes, and abilities indicate that they have the greatest potential for success in our program. Therefore, **we ask that you provide a thoughtful, accurate, and sincere appraisal of this applicant**. If you feel you do not know the applicant well enough to complete this form, please notify him/her and return this form to them. Your early reply is appreciated as the application deadline is December 15 of each year.

YOUR NAME: ______________________________________

TITLE: ______________________________________

ORGANIZATION: ______________________________________

STREET ADDRESS: ______________________________________

CITY: ____________________ STATE: _______ ZIP CODE: __________

WORK TELEPHONE: ( ) ______________________________

SIGNATURE:______________________________________

May we telephone you for clarification of comments if necessary? YES _____ NO _____

Thank you in advance for completing this recommendation form. We are aware of the time required and everyone involved in this process appreciates your response.

PLEASE RETURN THIS FORM IN A SEALED ENVELOPE TO THE APPLICANT WHO REQUESTED YOU TO COMPLETE THIS RECOMMENDATION. IF THIS IS NOT FEASIBLE, YOU MAY RETURN IT TO:

ATTN: PROGRAM DIRECTOR
CHI St. Alexius Health/University Of Mary
Radiologic Technology Program
900 E. Broadway Ave.
Bismarck, ND 58501

Personal And Professional Appraisal

Please rate the applicant in the following categories, using a scale of 1 to 5; with 5 being superior and 1 being poor. If you have no basis for evaluation in any category, please check "No Basis".

Characteristic	Superior 5	4	3	2	Poor 1	No Basis
Academic Potential						
Leadership						
Mathematics & Computer Skills						
Sense of Responsibility						
Ability to Work with People						
Organizational Ability						
Flexibility in Adapting to New Situations						
Ability to Work Independently						
Reliability						
Oral Communication Skills						
Written Communication Skills						
Problem Solving Ability						

Acquaintance With Applicant

How long have you known the applicant? ________________

In what capacity have you known this applicant? ____

Comments

Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional. Use an extra sheet if needed.

____

____

____

Recommendation

- ( ) Strongly Recommend
- ( ) Recommend
- ( ) Recommend with Reservations (please explain in comment section)
- ( ) Do Not Recommend

PERSONAL REFERENCE FORM
CHI ST. ALEXIUS HEALTH/UNIVERSITY OF MARY
RADIOLOGIC TECHNOLOGY PROGRAM

APPLICANT'S NAME: ____
LAST FIRST

TO THE APPLICANT: Students of the Radiologic Technology Program have the right to inspect their files upon request. So that the person you have requested to write a letter of recommendation will know their letter will be held in confidence or if the letter will be open to inspection, the following policy is stated:

"Letters of recommendation are destroyed at the time program selections are made and prior to the applicant becoming an official Radiologic Technology Program student. Therefore, **the applicant will never see these letters**. This policy assures the person writing the recommendation that this letter will remain confidential."

TO THE EVALUATOR: The above person is applying for admission into the above mentioned Radiologic Technology Program.

Personal recommendations are a very important part of the application. Each recommendation is reviewed by members of the Selection Committee. We attempt to select those individuals whose accomplishments, personal attributes, and abilities indicate that they have the greatest potential for success in our program. Therefore, **we ask that you provide a thoughtful, accurate, and sincere appraisal of this applicant**. If you feel you do not know the applicant well enough to complete this form, please notify him/her and return this form to them. Your early reply is appreciated as the application deadline is December 15 of each year.

YOUR NAME: ____

TITLE: ____

ORGANIZATION: ____

STREET ADDRESS: ____

CITY: ______________________ STATE: _______ ZIP CODE: __________

WORK TELEPHONE: ( ) ______________________________________

SIGNATURE: ____

May we telephone you for clarification of comments if necessary? YES _____ NO _____

Thank you in advance for completing this recommendation form. We are aware of the time required and everyone involved in this process appreciates your response.

PLEASE RETURN THIS FORM IN A SEALED ENVELOPE TO THE APPLICANT WHO REQUESTED YOU TO COMPLETE THIS RECOMMENDATION. IF THIS IS NOT FEASIBLE, YOU MAY RETURN IT TO:

ATTN: PROGRAM DIRECTOR
CHI St. Alexius Health/University Of Mary
Radiologic Technology Program
900 E. Broadway Ave.
Bismarck, ND 58501

Personal And Professional Appraisal

Please rate the applicant in the following categories, using a scale of 1 to 5; with 5 being superior and 1 being poor. If you have no basis for evaluation in any category, please check "No Basis."

Characteristic	Superior 5	4	3	2	Poor 1	No Basis
Academic Potential						
Leadership						
Mathematics & Computer Skills						
Sense of Responsibility						
Ability to Work with People						
Organizational Ability						
Flexibility in Adapting to New Situations						
Ability to Work Independently						
Reliability						
Oral Communication Skills						
Written Communication Skills						
Problem Solving Ability						

Acquaintance With Applicant

How long have you known the applicant? _______________

In what capacity have you known this applicant? ____

Comments

Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional. use an extra sheet if needed.

____

____

____

Recommendation

( ) Strongly Recommend
( ) Recommend
( ) Recommend with Reservations (please explain in comment section)
( ) Do Not Recommend

PERSONAL REFERENCE FORM
CHI ST. ALEXIUS HEALTH/UNIVERSITY OF MARY
RADIOLOGIC TECHNOLOGY PROGRAM

APPLICANT'S NAME:____

LAST FIRST

TO THE APPLICANT: Students of the Radiologic Technology Program have the right to inspect their files upon request. So that the person you have requested to write a letter of recommendation will know their letter will be held in confidence or if the letter will be open to inspection, the following policy is stated:

"Letters of recommendation are destroyed at the time program selections are made and prior to the applicant becoming an official Radiologic Technology Program student. Therefore, **the applicant will never see these letters**. This policy assures the person writing the recommendation that this letter will remain confidential."

TO THE EVALUATOR: The above person is applying for admission into the above mentioned Radiologic Technology Program.

Personal recommendations are a very important part of the application. Each recommendation is reviewed by members of the Selection Committee. We attempt to select those individuals whose accomplishments, personal attributes, and abilities indicate that they have the greatest potential for success in our program. Therefore, **we ask that you provide a thoughtful, accurate, and sincere appraisal of this applicant**. If you feel you do not know the applicant well enough to complete this form, please notify him/her and return this form to them. Your early reply is appreciated as the application deadline is December 15 of each year.

YOUR NAME: ______________________________

TITLE: ______________________________

ORGANIZATION: ______________________________

STREET ADDRESS: ______________________________

CITY: ________________ STATE: _____ ZIP CODE: ________

WORK TELEPHONE: ( ) ________________________

SIGNATURE:______________________________

May we telephone you for clarification of comments if necessary? YES _____ NO _____

Thank you in advance for completing this recommendation form. We are aware of the time required and everyone involved in this process appreciates your response.

PLEASE RETURN THIS FORM IN A SEALED ENVELOPE TO THE APPLICANT WHO REQUESTED YOU TO COMPLETE THIS RECOMMENDATION. IF THIS IS NOT FEASIBLE, YOU MAY RETURN IT TO:

ATTN: PROGRAM DIRECTOR
CHI St. Alexius Health/University Of Mary
Radiologic Technology Program
900 E. Broadway Ave

Bismack ND 58501

Personal And Professional Appraisal

Please rate the applicant in the following categories, using a scale of 1 to 5; with 5 being superior and 1 being poor. If you have no basis for evaluation in any category, please check "No Basis."

Characteristic	Superior 5	4	3	2	Poor 1	No Basis
Academic Potential						
Leadership						
Mathematics & Computer Skills						
Sense of Responsibility						
Ability to Work with People						
Organizational Ability						
Flexibility in Adapting to New Situations						
Ability to Work Independently						
Reliability						
Oral Communication Skills						
Written Communication Skills						
Problem Solving Ability						

Acquaintance With Applicant

How long have you known the applicant? ________________

In what capacity have you known this applicant? ____

Comments

Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional. use an extra sheet if needed.

____

____

____

Recommendation

( ) Strongly Recommend
( ) Recommend
( ) Recommend with Reservations (please explain in comment section)
( ) Do Not Recommend

PLEASE SIGN THE FOLLOWING RELEASES PERMITTING CHI ST. ALEXIUS HEALTH SCHOOL OF RADIOLOGIC TECHNOLOGY TO CHECK EDUCATIONAL AND PAST EMPLOYMENT REFERENCES.

RELEASE: Having made application for internship at CHI St. Alexius Health/University of Mary School of Radiologic Technology and desiring them to be informed of my previous record and character, I hereby authorize CHI St. Alexius Health/University of Mary School of Radiologic Technology to investigate my past record and to ascertain any and all information which may concern my record and character, whether same is of record or not, and release my present and past employers, references, and all persons whomsoever from any damage because of furnishing said information.

SIGNATURE ______________________________ DATE ____________________

RELEASE: Having made application for internship at CHI St. Alexius Health/University of Mary School of Radiologic Technology and desiring them to be informed of my previous record and character, I hereby authorize CHI St. Alexius Health/University of Mary School of Radiologic Technology to investigate my past record and to ascertain any and all information which may concern my record and character, whether same is of record or not, and release my present and past employers, references, and all persons whomsoever from any damage because of furnishing said information.

SIGNATURE ______________________________ DATE ____________________

RELEASE: Having made application for internship at CHI St. Alexius Health/University of Mary School of Radiologic Technology and desiring them to be informed of my previous record and character, I hereby authorize CHI St. Alexius Health/University of Mary School of Radiologic Technology to investigate my past record and to ascertain any and all information which may concern my record and character, whether same is of record or not, and release my present and past employers, references, and all persons whomsoever from any damage because of furnishing said information.

SIGNATURE ______________________________ DATE ____________________

RELEASE: Having made application for internship at CHI St. Alexius Health/University of Mary School of Radiologic Technology and desiring them to be informed of my previous record and character, I hereby authorize CHI St. Alexius Health/University of Mary School of Radiologic Technology to investigate my past record and to ascertain any and all information which may concern my record and character, whether same is of record or not, and release my present and past employers, references, and all persons whomsoever from any damage because of furnishing said information.

SIGNATURE ______________________________ DATE ____________________

Technical Standards

Please read the following statements identifying the technical standards appropriate to radiologic technology and answer the inquiry provided below.

The Radiologic Technologist must have sufficient strength, motor coordination, and manual dexterity to:

1. transport, move, lift, and transfer patients from a wheelchair or cart to an x-ray table or to a patient bed.
2. Move, adjust, and manipulate a variety of radiographic equipment, including the physical transportation of mobile radiographic machines, in order to arrange and align the equipment with respect to the patient and the image receptor according to established procedure and standards of speed and accuracy.

The Radiologic Technologist must be capable of:

1. Handling stressful situations related to technical and procedural standards and patient care situations.
2. Providing physical and emotional support to the patient during the radiographic procedures, being able to respond to situations requiring first aid and providing emergency care to the patient in the absence of, or until the physician arrives.
3. Communicating verbally in an effective manner in order to direct patients during radiographic examinations.
4. Reading and interpreting patient charts and requisitions for radiographic examinations.

The Radiologic Technologist must have the mental and intellectual capacity to:

1. Calculate and select proper technical exposure factors according to the individual needs of the patient and the requirements of the procedure's standards of speed and accuracy.
2. Review and evaluate the recorded images on radiographs for the purpose of identifying proper patient positioning, accurate procedural sequencing, proper radiographic exposure, and other appropriate and pertinent technical qualities.

Two years of college prerequisite courses are required to qualify for admission into the program. Please supply transcripts to verify completion of, or registration for, the courses necessary to qualify for admission. The best time to request transcripts from your university or college is at the conclusion of your fall semester when the fall grades will be finalized and the spring semester registration for classes will be included on your transcripts.

Your application is considered complete when the following are received by the program by December 15: high school transcripts, ACT results, signed reference release forms, fully completed and signed application form, three personal reference forms, and the nonrefundable application fee of $25.00.

We will need your college transcripts by January 1.

I certify that answers given on this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application as may be necessary in arriving at an admission decision. I understand that this application is not, and is not intended to be, a contract of admission. In the event of admission, I understand that false or misleading information given in this application or interview may result in immediate dismissal. I further understand that if selected for admission, CHI St. Alexius Health will request a personal background check be completed on me which also may compromise my position in the program if negative.

SIGNATURE: ______________________________ DATE: ____________________