

**APPLICATION FOR ADMISSION**

You must print legibly or type your responses. All blanks must be completed.

Have you applied previously to our program?  Yes  No When? \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**PERSON TO BE NOTIFIED IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**EDUCATION**

High School \_\_\_\_\_ City, State \_\_\_\_\_

Last grade completed \_\_\_\_\_ Did you graduate?  Yes  No  GED

College/University \_\_\_\_\_ City, State \_\_\_\_\_

Dates of Attendance \_\_\_\_\_ Degree/Major \_\_\_\_\_

College/University \_\_\_\_\_ City, State \_\_\_\_\_

Dates of Attendance \_\_\_\_\_ Degree/Major \_\_\_\_\_

College/University \_\_\_\_\_ City, State \_\_\_\_\_

Dates of Attendance \_\_\_\_\_ Degree/Major \_\_\_\_\_

Grade Transcripts: It is the responsibility of the applicant to have official high school and college transcripts (including the current semester) sent to us.

**ACT TEST**

Have you taken the ACT test?  Yes  No  If yes, when? \_\_\_\_\_

Did you have the results sent to Sanford Medical Center School of Radiologic Technology?  Yes  No.

If no, have scores sent to our program from ACT directly or on high school/college transcript.

**EMPLOYMENT HISTORY**

Employer \_\_\_\_\_ City, State \_\_\_\_\_ Job Title \_\_\_\_\_

Supervisor Name & Title \_\_\_\_\_ Phone \_\_\_\_\_ May we contact?  Yes  No

Duties \_\_\_\_\_

Dates Employed (MM/YY to MM/YY) \_\_\_\_\_

Employer \_\_\_\_\_ City, State \_\_\_\_\_ Job Title \_\_\_\_\_

Supervisor Name & Title \_\_\_\_\_ Phone \_\_\_\_\_ May we contact?  Yes  No

Duties \_\_\_\_\_

Dates Employed (MM/YY to MM/YY) \_\_\_\_\_

Please attach an additional sheet for additional work/volunteer experiences, if needed.

## REFERENCES

(Reference suggestions: teacher, coach, counselor, employer, clergy)

Name \_\_\_\_\_ Title \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## APPLICATION FEE

For application completion, a non-refundable \$35 application fee must be included with the application to be considered for an interview. Please submit a check or money order for \$35 payable to Sanford Medical Center School of Radiologic Technology.

## IMPORTANT

The ARRT Registry Exam application asks if you have ever been convicted of a misdemeanor, felony or a similar offense in a military court-martial. If you have any eligibility concerns, in order to receive important information regarding registrant eligibility, **prior to seeking entrance to this or any radiography program**, contact the American Registry of Radiologic Technologists, 1255 Northland Drive, Mendota Heights, MN 55120.

I hereby affirm that all information contained in this application is true and complete and that any falsification shall be sufficient reason for rejection of my application or dismissal, if accepted into the radiologic technology program.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Note:** The processing of this application will be accelerated by prompt receiving of the above-specified information. When this has been accomplished, you will be contacted for a personal interview. The entire application process **MUST** be completed and received by the program by January 31st.

MAIL APPLICATION AND CREDENTIALS TO: Sanford Medical Center  
School of Radiologic Technology  
Attn: Emily Pociask/Program Director  
1305 W 18th Street, PO Box 5039  
Sioux Falls, SD 57117-5039