

*Harris County Hospital District
School of Medical Radiography
5656 Kelley Street Houston Texas 77026 (713) 566-4736*

Student Application Form

Name	SSN
Current Address	City/State/Zip
Email address	
Telephone: Home	Telephone: Work
In case of an emergency, notify: Relationship:	Telephone - Home: - Work:

Who referred you to the program?	Have you made application to another medical radiography program this year or in the past?	If so, which schools?
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Have you ever been convicted of, plead guilty or no contest (<i>nolo contendere</i>), or received deferred adjudication for any criminal offense (include misdemeanors and felonies)? Answering "Yes" will not automatically bar you from admission.	Yes	No
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Have you ever worked in a health care facility?	Yes	No	If yes, explain briefly
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Education and Training

	High School	College	Graduate School	Business/Technical
Name of School				
Address City/State/Zip				
Circle highest grade completed	1 2 3 4	1 2 3 4		
Graduation Date or Years attended				
Major/Minor				

Professional Licenses/Certifications

Type of License	License Number	Date/Place of Issue	Expiration Date

Indicate membership(s) in professional organizations (exclude those which may disclose your race, color, religion, or national origin):
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How do you consider your health?	Excellent	Good	Fair	Poor
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Military:

Branch of Service	Date Entered	Date Discharged	Type of Discharge
Rank at Discharge		Are you a member of the Reserves?	
		Yes	No
		Active	Inactive
Duties and Special Training			

Employment History:

A complete application is required with or without a resume. List all current and former employment beginning with the most recent (attach additional sheet if necessary).

1. Employer	Dates Employed	Work Performed	Job Title
Address		Responsibilities:	
City/State/Zip			
Reason for Leaving:			
2. Employer	Dates Employed	Work Performed	Job Title
Address		Responsibilities:	
City/State/Zip			
Reason for Leaving:			

Explain in the space provided why you chose to pursue medical radiography as a career (attach additional sheet if necessary):

Applicant's Statement (Please Read):

I certify that the foregoing information is true and correct to the best of my knowledge. I understand that any misrepresentation or willful omission of the facts shall be cause for rejection of the application or for dismissal from the medical radiography program. I authorize the Harris County Hospital District to verify my employment history, personal references, military information, and driving and police record to determine my eligibility for admission. I hereby understand and acknowledge that the Hospital District makes no commitment of admission into the program by accepting this application. I understand and agree that as a condition of admission I will be required to pass a scheduled physical examination, which includes drug testing. I further agree to observe all rules, regulations and policies of the medical radiography program and the Hospital District.

Signature

Print Name

Date

Revised August 2006