

**EDUCATIONAL PROGRAMS IN MEDICAL IMAGING TECHNOLOGIES
PROGRAM OF MAGNETIC RESONANCE IMAGING
UNIVERSITY OF VIRGINIA HEALTH SYSTEM
DEPARTMENT OF RADIOLOGY, P.O. BOX 800377
CHARLOTTESVILLE, VIRGINIA 22908-0377
Telephone: (434)-982-1563 FAX: (434)-982-0626
E-Mail: gds7x@virginia.edu
Website: <http://www.healthsystem.virginia.edu/internet/radiology/>**

APPLICATION FOR STUDENT APPOINTMENT (Please type or print)

Name in Full: _____ S.S.# _____
Last First Middle

Present Address: _____
Street and No.

City and State with Zip Code

Permanent Address: _____
Street and No.

City and State with Zip Code

Home Phone: _____ Business Phone: _____
Area Code and No. Area Code and No.

Cell Phone: _____
Area Code and No.

A. EDUCATION

SCHOOL	NAME AND LOCATION OF SCHOOL	YEARS ATTENDED		GRADUATED YES OR NO	CERTIFICATE, DEGREE DIPLOMA RECEIVED DATE
		From	To		
High School					
College					
Program of Radiography					
Other					

If course was not completed, state reason _____

Date of A.R.R.T. Examination (Completed or Anticipated Test Date) _____

What formal class work and clinical experience have you had in the program area for which you are applying? _____

How were you informed about the program for which you are applying? _____

Briefly state why you have chosen to specialize in this field of Radiology? _____

Experience or skills not previously mentioned which you feel may be significant. _____

B. EMPLOYMENT

List last employer first. Give dates employed.

Name and Address Previous Employers	Type of Business	Employed		Position Held	Reason for Leaving
		From	To		

C. REFERENCES

List four references: The program director of the Radiography Program in which you received your training, the instructor of the science courses for the radiography program, the director of the college courses you may have had, a radiologist, and your present supervisor or clinical instructor. Send letters of references to address below.

NAME AND TITLE	ADDRESS (STREET AND NO., CITY, STATE & ZIP CODE)
1.	
2.	
3.	
4.	

Suggested date for personal interview (Monday-Friday): _____
 (May-June)

Tuition is \$1200.00 per nine-month session. Additional fees are required for textbooks and uniforms.

1. Have you ever applied to this program before? Yes or No
2. Have you ever been convicted of a felony or misdemeanor? Yes or No (If yes, please explain)

The above information is complete and correct to the best of my knowledge. False statements will be grounds for dismissal. All information will be kept strictly confidential; permission is granted to check with previous educators/employers.

Date: _____ Applicant's Signature: _____

Return the completed application form by **May 1st** and send your high school, radiography program and college transcripts and registry verification to:

University of Virginia Health System
 Educational Programs in Medical Imaging Technologies
 Educational Director
 Department of Radiology, Box 800377
 Charlottesville, Virginia 22908-0377
 Attn: Gina S. Christopher, R.T. (R)(T)(CT)

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DISCLAIMER CLAUSE

The provisions of this brochure/application are not to be regarded as an irrevocable contract between the student and the University of Virginia Health System. The University of Virginia Health system reserves the right to change any provision or requirement at any time within the student's term of enrollment. Any changes will be made known to the student through periodic updates.