WELLSPAN HEALTH RADIOGRAPHY PROGRAM

Application for Admission to class beginning August _________ (year)

PERSONAL INFORMATION

Name: ____ ____________________
Last First M.I. Social Security #

Former Name: ____ ______________
(If any) Last First Middle Initial

Home Address: ____
Number and Street

____
City State Zip Code

Home Telephone: (______)____________________ Cell Telephone: (______)__________________

E-Mail Address: ____

Person to be notified in an Emergency:

Name: ______________________________ ____ Relationship:____________________

Address: ______________________________ ______________________________

Telephone Number: (______)______________________

Are you a citizen of the United States or a national of the United States or an Alien lawfully for permanent residence or an Alien authorized to work in the U.S? ☐ Yes ☐ No
If No, type of entry document and serial number:_________________________________

Are you fluent in a second language? ☐ Yes ☐ No If Yes, indicate second language: ________________

Have you been convicted or under indictment for a misdemeanor or felony? ☐ Yes ☐ No
If yes, provide a letter of explanation.

Note: A conviction will not necessarily prevent admission to the WellSpan Health Radiography Program.
Nature of offense, aggravating and mitigating circumstances, and future eligibility for ARRT certification will be considered. Candidates must seek pre-approval through the ARRT. The ARRT may be contacted at (651) 687-0048 for individual consultation.

EDUCATION

List all High School and Post-High School experiences in chronological order. Any additional school please attach with a separate sheet of paper. Official transcripts from high school and all institutions attended must be sent to the program as part of the application process.

Name of Schools	City/State	Course of Study	Diploma/Degree	Dates Attended
High School				
College, Technical, Other School			**Graduated?** ☐ Yes ☐ No	**From To**
College, Technical, Other School			**Graduated?** ☐ Yes ☐ No	**From To**
College, Technical, Other School			**Graduated?** ☐ Yes ☐ No	**From To**

If you hold a High School Equivalency or GED please list: **State** ___________________________________
Date Received ___________________________
Certificate Number _____________________

If you are attending or have attended a Radiography Program give the following:
Name of School: ____

Address: ____

Date of Entrance: ___________________________ Date Withdrew: __________________________

Reason for Leaving:
____
____
____

REFERENCES

List three references. Select from the following: Professional, Academic, or Employer.
Please have each individual listed submit a completed Reference Form to the program.
(Reference Form is found at the end of application.)

1. Name ______________________ Title ______________
   Address ______________________________________
   Street City/State Zip Code

2. Name ______________________ Title ______________
   Address ______________________________________
   Street City/State Zip Code

3. Name ______________________ Title ______________
   Address ______________________________________
   Street City/State Zip Code

EMPLOYMENT HISTORY

Please begin with your current or most recent employment. List all employers within the previous 5 years. Use an additional sheet of paper if necessary.

Employer ______________________ Employed from ______ to ______
Address ______________________ Position Held ______________
Job Responsibilities ______________________ Supervisor's Name ______________

Employer ______________________ Employed from ______ to ______
Address ______________________ Position Held ______________
Job Responsibilities ______________________ Supervisor's Name ______________

Employer ______________________ Employed from ______ to ______
Address ______________________ Position Held ______________
Job Responsibilities ______________________ Supervisor's Name ______________

Students are required to meet the program’s prerequisites, which include Mathematical Logical Reasoning (College Algebra or higher), Written/Oral Communication, Human Anatomy and Physiology I (4 credit course minimum), Human Anatomy and Physiology II (4 credit course minimum) and Medical Terminology (1 credit course minimum or certificate).

College Course Selection

College classes must be chosen from the following list to satisfy the program’s prerequisite requirements. Program enrollment is contingent on passing all required courses with a 2.0 “C” or greater.

Prerequisite	Requirements	Yes Year	No	Currently Enrolled	College
Mathematical Logical Reasoning	**3 credit minimum PREREQUISITE “College Algebra” course or higher**				
Written/Oral Communication	**3 credit minimum PREREQUISITE**				
Natural Sciences (A&P I, II with Lab)	**8 credit minimum PREREQUISITE (A&P II may be completed summer semester of enrollment year)**				
Medical Terminology	**1 credit minimum or Certificate PREREQUISITE**				

- **Students must have an associate degree or higher or be eligible to receive an associate’s degree or higher upon completion of the program**.
- **Students may achieve program prerequisite and degree requirements through a Regional Accredited College, such as, Middle State Association of Colleges and Schools**

Do you have previous medical experience? _____ Yes _____ No

Please list medical skills that you possess:

Have you ever worked/volunteered in a customer service role or worked with the public? _____Yes _____ No

If yes, please describe:

PROFESSIONAL CAREER STATEMENTS

State briefly on a separate sheet of paper (Please Type):

1. **Why are you interested in a career in Radiologic Technology?**
2. **Do you have any special reasons for desiring to enter this program?**
3. **How did you hear about the WellSpan Health Radiography Program?**
4. **What skills or characteristics (i.e., language skills) distinguish you from other applicants?**

PLEASE READ CAREFULLY BEFORE SIGNING

Technical Standards

To participate in the clinical education portion of the program, the applicant must possess additional non-academic skills. These technical standards are consistent with the duties of the entry-level radiographer in a professional position. **These standards are not limited to, but include:**

- ***Communication*** – verbal and non-verbal communication between patients, co-workers, visitors and physicians. Must be able to read, write, and speak the English language and communicate in an understandable manner.
- ***Auditory Skills*** – hearing a patient's, co-worker's or visitor's request for help, and taking instructions from physicians and supervisors.
- ***Psychomotor Skills and Coordination*** – performs physical movements required in lifting and moving patients and handling radiographic equipment.
- ***Visual Acuity*** – reading instructions, books, computer screens, technique charts, and patient requisitions with extreme accuracy. Must be able to view images for accuracy.
- ***Dexterity*** – manipulating radiographic equipment and computer skills.
- ***Emotional Maturity*** – possesses emotional health necessary to fulfill program requirements, such as, integrity, compassion, initiative, and good judgment in stressful situations.

Conditions inhibiting the above listed technical standards may be reviewed by the admission committee. Every effort will be made to make reasonable accommodations when necessary.

All applicants are considered for admission without regard to: race, creed, color, national origin, marital status, gender, age, sex, sexual preference, sexual origin, or disability; provided the applicant can meet the requirements of the program (please see Technical Standards).

The program shall protect the confidentiality of student records as dictated by the Family Educational Rights and Privacy Act (FERPA) and shall release no information absent written consent of the student unless required to do so by law or as dictated by the terms of this agreement.

ARRT Ethics Requirements: Students who have been convicted of a felony or misdemeanor may have violated the American Registry of Radiologic Technologists (ARRT) Rules of Ethics, and may be considered ineligible to sit for board examinations. Individuals may submit a pre-application form to the ARRT (651-687-0048) at any time either before or after entry into an approved educational program.
Please Note: a PA State Police Record clearance, FBI Fingerprint Clearance, and PA Child Abuse History clearance will be required if you are accepted into the program.

Permission is hereby given to the WellSpan Health Radiography Program to investigate all pertinent information concerning my application in order to determine my qualifications for admission. I understand that any willful misrepresentation or omission of fact contained in this application will be the cause for rejection or dismissal.

______________________________ ______________________________________

Date Signature of Applicant

APPLICATION PROCEDURE

The applicant is responsible for all information, which includes; the completed application, $35.00 dollar non-refundable application fee, transcript forms/official transcripts, three reference letters, observation form, and professional career statements. **Please send a Money Order or Certified Check for the application fee; Cash and Personal Checks are not accepted. Make payment payable to Radiography Program. All of the above information must be received by the WellSpan Health Radiography Program by January 31st.** For more information or questions, please call the program at (717) 812-3599 or e-mail tszczypinski2@wellspan.org

Please mail to:
WellSpan Health Radiography Program
37 Monument Road
Suite 101
York, PA 17403

WellSpan Health Radiography Program

Observation Form

All applicants are required to observe at **least 3 hours at "any" Radiology Department of their choice** before the deadline of applications, which is January 31st if available due to observation restrictions. The following must be completed by one of the following representatives: **Program Faculty member, Radiology Director, Chief Technologist, or Department Manager**

Observational Student: ____

Name of Hospital: ____

Date/Time: ____

______________________________________ ______________________________________

Representative Signature **Title**

If you would like to shadow at York Hospital, York Hospital Imaging Center, or Gettysburg Hospital please contact Tracy Szczypinski by calling 717-851-4438. Information about the York Hospital Student Shadowing Program is on the following web site www.wellspan.org under careers/exploration and development.

If you have any questions please feel free to contact:
WellSpan Health Radiography Program at (717) 812-3599 or Fax at (717) 812-3809

***This form must be returned along with your application by January 31st.**

WellSpan Health Radiography Program
37 Monument Road, Suite 101
York, PA 17403

Reference Form

Applicant's Name: ____
Reference's Name: ____

The applicant has applied to the WellSpan Health Radiography Program. Please complete this reference form and mail it directly to the school. **No letters will be accepted.**

How long have you known the applicant? ____
In what capacity? ____

What do you consider the chief strength and weakness of the applicant? If possible, give examples.

Please rate the applicant in the following categories on a scale of 1 to 5 (5=excellent, 1=poor)

a. Academic potential _____
b. Honesty _____
c. Personality _____
d. Dependability _____
e. Adaptability _____
f. Communication skills _____
g. Responsibility ______
h. Initiative ______
i. Leadership ______
j. Teamwork ______
k. Maturity ______

Additional comments:
____
____
____
____
____

Recommendation:

__________ Recommend
__________ Recommend with reservation (explain)
________Strongly Recommend
________ Do not recommend

Signature: ____Date:________________

Address: ____

Revised 4/12/24