

School of Radiography

1000 North Village Avenue
Rockville Centre, NY 11570
(516) 705-2274



Application for Admission: Class of 2029

Directions: Please print or type. This is an important application. Complete it carefully and accurately and return to the address above. Misrepresentation of application information is sufficient grounds for canceling admission or termination from the program.

Date: _____ Social security number: _____

Name (print in full)

First name	Last name	Maiden name (if applicable)
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Home address

Number and street	City	State	Zip
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Contact number (_____) _____ Cell ☐ Home ☐ Email: _____

U.S. Citizenship: Yes ☐ No ☐ Visa status: _____ Are you between the ages of 18-70? Yes ☐ No ☐

Have you ever been convicted of a criminal offense? (felony/misdemeanor) An affirmation response will not automatically exclude anyone from the program. If you have ever been convicted of a crime (other than a parking violation), involved in a crime of moral turpitude, or convicted of driving while intoxicated, a felony, you must check with the New York State Department of Health to verify that you satisfy requirements for licensing and National Registry.

No ☐

Yes ☐

Education

Our standards for acceptance require a successfully conferred two-year college degree or better.

I attest that I have an accredited: ☐ associate's degree ☐ bachelor's degree ☐ master's degree.

Name of school/university	Address	From	To	Diploma/Degree earned

Employment (list most recent employment first)

Date	Employer's name & address	Position	Reason for leaving
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			

Professional references

Give us the names & addresses/e-mail of three individuals whom we may contact who have known you for at least two years. No relatives.

Name	Address and/or email	Relationship	# of years

Military service record

Dates served

From: _____ To: _____

Branch of service: _____ Type of discharge: _____

What special skills did you develop in the service? _____

Additional information

Have you ever attended another school of radiologic technology? Yes ☐ No ☐ _____

How did you find out about our program? _____

Have you ever had any previous healthcare experience? Yes ☐ No ☐

Where? _____

Please describe skills or specialized experiences that you feel would be helpful in considering your qualifications (example: hospital volunteer, CPR training, etc.)

- **On a separate piece of paper, please write a personal letter telling us about yourself and how you became interested in the field of radiography.**
- **Please have your college remit official transcripts to Mercy Hospital School of Radiography. The application process cannot proceed further without these official transcripts.**
- **Please enclose the non-refundable application fee for \$100 in a check or money order.**

The above answers are true and complete, to the best of my knowledge. I understand and agree that the discovery of any misinterpretation or omission in this application may prevent me from being accepted to the Mercy Hospital School of Radiography and may result in my immediate dismissal from the program after acceptance. If I accept this appointment, I agree to abide by the rules and policies and regulations set forth by Mercy Hospital and its School of Radiography.

Signature of applicant: _____ Date: _____

The Mercy Hospital School of Radiography does not discriminate against applicants on the basis of sex, age, race, color, religion, and marital status, status in regards to public assistance, sexual preference or national origin in the administration of admissions or educational policies.