

Philadelphia School of Radiologic Technology

St. Christopher's Hospital for Children

Erie Avenue at Front Street

Philadelphia, PA 19134

Application for Admission

(Please Type or Print in Ink)

Name In Full _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone (_____) _____

Social Security Number _____

(Education)

High School or G.E.D. _____

Address _____

Date of Graduation or G.E.D. _____

College (most recent) _____

Address _____

Dates of Attendance _____

Degree Awarded and Date of Graduation: _____

College (other) _____

Address _____

Dates of Attendance _____

Degree Awarded and Date of Graduation _____

Other *Post-Secondary* Education _____

Dates of Attendance _____

Have you received previous Radiography education? _____

If so, Where? _____

(Employment Experience)

Employer (most recent) _____

Address _____

Phone (_____) _____

Date of Employment _____

Nature of Employment _____

Employer (other) _____

Address _____

Phone (_____) _____

Date of Employment _____

Nature of Employment _____

Have you ever been convicted of a crime? _____ **Yes** _____ **No**

To qualify as a candidate for certification by the American Registry of Radiologic Technologists (ARRT), all Registered Technologists and applicants must comply with the "Rule of Ethics" contained in the ARRT Standards of Ethics. One issue addressed by the Rule of Ethics is the conviction of a crime, including a felony, a gross misdemeanor, or a misdemeanor with the sole exception of speeding and parking violations. Personal concerns regarding this question should be directed to the American Registry of Radiologic Technologists, St. Paul, Minnesota 612-687-0048, before completing this application.

Nondiscriminatory Policy: The School of Radiologic Technology does not discriminate on the basis of race, color, religion, sex, sexual preference, disability, age, or national origin in administration of educational policies, admissions policies, or other school administered programs.

I hereby apply for admission to the School of Radiologic Technology of St. Christopher's Hospital for Children. I certify that the information included in this application is true and complete to the best of my knowledge. I fully realize that omission or falsification of application information will be considered sufficient reason for rejection of this application or dismissal from the school should I be accepted. If admitted, I agree to abide by all school policies.

Signature of Applicant: _____

Date: _____