



Application Diagnostic Medical Sonography Program 2012-2013

Please Type or Print

**Application fee: \$25.00 Non-refundable
Deadline for 2012-2013: June 24, 2011**

LAST NAME	FIRST NAME	M.I.	
FORMER NAMES (MAIDEN, FORMER MARRIED NAMES)		SOCIAL SECURITY NUMBER	
PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE
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HOME TELEPHONE	WORK TELEPHONE	EMAIL ADDRESS	
SEX: _____ MALE	_____ FEMALE	CITIZENSHIP: _____ U.S.A.	_____ OTHER
FOREIGN STUDENT REQUIREMENTS: IS ENGLISH YOUR SECOND LANGUAGE:		_____ Yes	_____ No
IF YES, PLEASE REFER TO FOREIGN STUDENT POLICY			

Person to be notified in case of emergency:

NAME	RELATIONSHIP	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

Please list each school attended and send official transcripts to School of Diagnostic Medical Sonography:

HIGH SCHOOL	CITY	STATE	DATE GRADUATED
COLLEGE	CITY	STATE	DEGREE
RADIOGRAPHY PROGRAM	CITY	STATE	COMPLETION DATE
A.R.R.T. I.D. NUMBER	DATE	IF REGISTRY-ELIGIBLE, DATE TEST WILL BE TAKEN	

Employment History: Please list your last 3 places of employment.

EMPLOYER

JOB TITLE (RESPONSIBILITIES)

DATE OF EMPLOYMENT

References: Provide names of three individuals who are familiar with your work or educational experience in a medical or science-related field (other than those on your Reference Forms):

NAME

STREET ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

Certain felony convictions may disqualify an applicant who has completed this program from taking the national board exam (Registry) as administered by the American Registry of Diagnostic Medical Sonography as established by their by-laws.

Have you ever been convicted of a felony Yes _____ No _____ If yes, Please Explain.

Completion of a Job Shadow in Diagnosis Medical Sonography: Yes ___ No ___ Date _____

Institution _____ Number of hours _____

Write a brief paragraph explaining why you would like to be accepted to the School of Diagnostic Medical Sonography Program.

I understand that I must submit official transcripts from all schools, college or universities that I have attended. I certify that, to the best of my knowledge, all statements I have made in this application are complete and true. Failure to provide accurate information may result in denial of this application and/or dismissal from Saint Luke's Health System Diagnostic Medical Sonography Program.

SIGNATURE

DATE

Saint Luke's Health System does not discriminate on the basis of sex, race, religion, age, color, handicap, sexual orientation, or national origin in the administration of its educational policies.

MAIL APPLICATION AND FEE (make payable to SLHS SCHOOL OF DIAGNOSTIC MEDICAL SONOGRAPHY) TO:

Department of Radiology
Saint Luke's Hospital
School of Diagnostic Medical Sonography
4401 Wornall Road
Kansas City, MO 64111