



# SAINT LUKE'S HOSPITAL

## Application

### School of Radiologic Technology

2010-2012

Please Type or Print

Application fee: \$25.00 Non-refundable  
Deadline: January 15<sup>th</sup>, 2010

LAST NAME		FIRST NAME		M.I.			
FORMER NAMES (MAIDEN, FORMER MARRIED NAMES)		DATE OF BIRTH		SOCIAL SECURITY NUMBER			
ADDRESS		CITY		STATE		ZIP CODE	
( )		( )					
HOME TELEPHONE		WORK TELEPHONE		EMAIL ADDRESS			
GENDER: _____ 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	
OPTIONAL INFORMATION:							
RELIGIOUS AFFILIATION: _____							
ETHNIC ORIGIN:		<input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE		<input type="checkbox"/> AFRICAN AMERICAN			
		<input type="checkbox"/> ASIAN/PACIFIC ISLANDER		<input type="checkbox"/> CAUCASIAN			
		<input type="checkbox"/> HISPANIC		<input type="checkbox"/> OTHER: SPECIFY: _____			

**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 Attention: Program Director:**

HIGH SCHOOL		CITY		STATE		DATE GRADUATED	
COLLEGE		CITY		STATE		DEGREE	
OTHER		CITY		STATE		COMPLETION DATE	

ATTACH AN ADDITIONAL SHEET IF NEEDED

**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 experience:**

NAME

STREET ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

**Have you ever been convicted of a crime? NO: \_\_\_\_\_ YES: \_\_\_\_\_ If yes, Please Explain.**

Individuals who have been convicted of a crime must be approved by the American Registry of Radiologic Technology prior to making application to the program (see the CERTIFICATION ELIGIBILITY STATEMENT ENCLOSED IN THE INFORMATION PACKET) Certain convictions may disqualify an applicant from taking the National Certification Examination as administered by the American Registry of Radiologic Technologist (ARRT) as established by their by-laws. Saint Luke's Hospital requires that all students must submit to a criminal background check, prior to admittance into the program.

**Completion of a Job Shadow in Diagnosis Radiology: Yes \_\_\_ No \_\_\_ Institution \_\_\_\_\_**

Date \_\_\_\_\_ Number of hours \_\_\_\_\_

Write a brief paragraph explaining why you want to become a Radiologic Technologist

**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 Hospital School of Radiologic Technology Program.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**Saint Luke's Hospital 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 SLH SCHOOL OF RADIOLOGIC TECHNOLOGY) TO:**

School of Radiologic Technology  
Saint Luke's Hospital  
Attn: Admissions  
4401 Wornall Road  
Kansas City, MO 64111