



**WELLSPAN HEALTH RADIOGRAPHY PROGRAM**

**Application for Admission to class beginning August \_\_\_\_\_ (year)**

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**PERSONAL INFORMATION**

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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: \_\_\_\_\_

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**Person to be notified in an Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

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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: \_\_\_\_\_

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Are you fluent in a second language?  Yes  No If Yes, indicate second language: \_\_\_\_\_

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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.

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**EDUCATION**

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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 school.**

Name of Schools	City/State	Course of Study	Diploma/Degree	Dates Attended
High School				
College, Technical, Other School			Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	From To
College, Technical, Other School			Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	From To
College, Technical, Other School			Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> 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 school.**  
 (Reference Form is found at the end of application.)



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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 _____

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### EMPLOYMENT HISTORY

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**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 _____

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Employer _____	Employed from _____ to _____
Address _____	Position Held _____
Job Responsibilities _____	Supervisor's Name _____

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Employer _____	Employed from _____ to _____
Address _____	Position Held _____
Job Responsibilities _____	Supervisor's Name _____

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Students are required to have an associate's degree of higher or be eligible to receive an associate's degree or higher upon completion of the program.

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) **A&P I & II must be completed at the same college institution**, 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.

Enrollment	Requirements	Yes Year	No	Currently Enrolled	College
Mathematical Logical Reasoning	<b>3 credit minimum PREREQUISITE</b> <b>"College Algebra" course or higher</b>				
Written/Oral Communication	<b>3 credit minimum PREREQUISITE</b>				
Natural Sciences (A&P I, II with Lab)	<b>8 credit minimum PREREQUISITE</b> <b>(A&amp;P II may be completed spring semester of enrollment year)</b>				
Medical Terminology	<b>1 credit minimum or Certificate PREREQUISITE</b>				

- **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 you are interested in a career in Radiologic Technology?**
- 2. Do you have any special reasons for desiring to enter this school?**
- 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?**



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**PLEASE READ CAREFULLY BEFORE SIGNING**

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**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, religion, marital status, age, sex, sexual preference, sexual origin or disability.

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 criminal background check 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.

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Date

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Signature of Applicant

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**APPLICATION PROCEDURE**

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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 31<sup>st</sup>.** For more information or questions, please call the school at (717) 812-3599 or e-mail at [radiographyprogram@wellspan.org](mailto:radiographyprogram@wellspan.org)

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

Revised 3/21/17



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 31<sup>st</sup>. The following must be completed by one of the following representatives: **School 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 the Human Resource Department by calling 717-851-2302. Information about the York Hospital Student Shadowing Program is on the following web site [www.wellspan.org](http://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 31<sup>st</sup>.**



37 Monument Road, Suite 101  
York, PA 17403

## Reference Form

Applicant's Name: \_\_\_\_\_  
Reference's Name: \_\_\_\_\_

The above named 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.

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

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

Additional comments:

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Recommendation:

\_\_\_\_\_ Recommend \_\_\_\_\_ Recommend strongly  
\_\_\_\_\_ Recommend with reservation (explain) \_\_\_\_\_ Do not recommend

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_