

**Harris Health System
School of Diagnostic Medical Imaging**

Application Instructions and Check List. Please check program of choice.

RADIOGRAPHY

SONOGRAPHY

Instructions:

1. Complete application
 - Make sure application is dated and signed
2. Include application fee
 - Money Order or Cashier's Check - **ONLY**
3. Essay
 - Write essay as a separate document to accompany application
4. Letters of recommendation must be completed by someone who can evaluate academic or employment performance.
 - May be submitted with application or mailed by recommending person.
5. Official transcripts
 - A. Sealed official transcripts can be sent with application or mailed directly from institution.
 - B. Foreign transcripts must be evaluated by appropriate agency before being submitted.
 - C. Must include a GPA.
6. Application and all required documentation must be submitted by March 1.

Send application and all required documents to:

Harris Health System
School of Diagnostic Medical Imaging
9250 Kirby, Suite 1800
Houston, Texas 77054

Application Check List;

- Completed application with essay
- \$35 application fee
- Two letters of recommendation
- Official college transcripts

Direct all questions to:

Ms. Faye Vance: (713) 634-1550

or by email: **bertha.vance@harrishealth.org**

Harris Health System
School of Diagnostic Medical Imaging
 9250 Kirby Drive, Suite 1800, Houston Texas 77054
 (713) 634-1550 or (713) 634-1553

Student Application Form

Name:	SSN:
Current Address:	City/State/Zip:
Email Address:	
Telephone: Home Telephone: Cell	Telephone: Work
In case of an emergency, notify: Relationship:	Telephone - Home: - Cell:

Which program are you applying?	<input type="checkbox"/> Radiography <input type="checkbox"/> Sonography <input type="checkbox"/> CT Fellowship <input type="checkbox"/> MRI Fellowship			
Who referred you to the program?	Have you made application to another medical imaging program this year or in the past?	If so, which schools?		
Have you ever been convicted of, plead guilty or no contest (<i>nolo contendere</i>), or received deferred adjudication for any criminal offense (include misdemeanors and felonies)? Answering "Yes" will not automatically bar you from admission.			Yes	No
Have you ever worked in a health care facility?	Yes	No	If yes, explain briefly	

Education and Training

	High School	College	Graduate School	Business/Technical
Name of School				
Address City/State/Zip				
Circle highest grade completed	9 10 11 12	1 2 3 4		
Graduation Date or Years attended				
Major/Minor				

Professional Licenses/Certifications

Type of License	License Number	Date/Place of Issue	Expiration Date

Indicate membership(s) in professional organizations (exclude those which may disclose your race, color, religion, or national origin):				
How do you consider your health?	Excellent	Good	Fair	Poor

Military:

Branch of Service	Date Entered	Date Discharged	Type of Discharge
Rank at Discharge		Are you a member of the Reserves? Yes No Active Inactive	
Duties and Special Training			

Employment History:

A complete application is required with or without a resume. List all current and former employment beginning with the most recent (attach additional sheet if necessary).

1. Employer	Dates Employed	Work Performed	Job Title
Address City/State/Zip		Responsibilities:	
Reason for Leaving:			
2. Employer	Dates Employed	Work Performed	Job Title
Address City/State/Zip		Responsibilities:	
Reason for Leaving:			

NOTE: Explain on a separate sheet of paper why you chose to pursue medical imaging as a career.

Applicant's Statement (Please Read):

I certify that the foregoing information is true and correct to the best of my knowledge. I understand that any misrepresentation or willful omission of the facts shall be cause for rejection of the application or for dismissal from the medical radiography program. I authorize the Harris Health System to verify my employment history, personal references, military information, and driving and police record to determine my eligibility for admission. I hereby understand and acknowledge that Harris Health System makes no commitment of admission into the program by accepting this application. I understand and agree that as a condition of admission I will be required to pass a scheduled physical examination, which includes drug testing. I further agree to observe all rules, regulations and policies of the medical imaging school and the Harris Health System.

 Signature

Print Name

Date

**Harris Health System
School of Diagnostic Medical Imaging**

Letter of Recommendation

Radiography Sonography CT Fellowship MRI Fellowship

Name of Applicant	
Name of Reference	

The applicant named above has applied for admission to the Harris Health System - School of Diagnostic Medical Imaging.

We are interested in obtaining information that will aid us in student selection. Applicants who are selected must not only be capable of completing academic requirements of the program, but must also possess the personal qualifications essential to competent professional clinical performance.

The applicant has selected you as someone who can give such an appraisal. We would appreciate your evaluation of the applicant. The pending application will be considered incomplete until your response has been received.

I. Acquaintance with Applicant

A. How long have you known the applicant? _____
B. In what capacity have you known the applicant? _____

II. Personal and Professional Appraisal (please check the appropriate category which best indicates your evaluation of the applicant)

Characteristics	Above Average	Average	Below Average	No Basis for Evaluation
Academic potential				
Leadership				
Sense of Responsibility				
Ability to work with people				
Ability to adapt to new situations				
Ability to work independently				
Reliability				
Oral communication				
Written communication				
Ability to analyze problems				
Problem solving skills				
Dependability				

III. Comments (Use Extra Sheet if Needed)

IV. Recommendation for Acceptance (Check one):

<input type="checkbox"/>	Strongly Recommend
<input type="checkbox"/>	Recommend
<input type="checkbox"/>	Recommend with reservations as noted in the comment section
<input type="checkbox"/>	Do not recommend

Please type or print:

Name	Title
Organization	
Address	
Telephone Number	
Signature	Date

Please return to:

Harris Health System
School of Diagnostic Medical Imaging
9250 Kirby Dr., Suite 1800
Houston, Texas 77054