HARRISHEALTH SYSTEM

School of Diagnostic Medical Imaging
4800 Fournace Place, Bellaire, Texas 77401
346-426-1530

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?	☐ **Radiography** ☐ **Sonography** ☐ **CT Fellowship** ☐ **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 *(nolo contendere)*, 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				

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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:			

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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 Heath 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**

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

_____

Signature: **Date:**