School of Radiography • 740 East State Street • Sharon, PA 16146 • 724-983-5645 www.sharonregional.com
Robert Piccirillo, Program Director

APPLICATION FOR ADMISSION

Deadline for Application and All Materials – January 31st of each year.

Sharon Regional Health System is an Equal Opportunity Facility. Applicants' recruitment practices at SRHS, School of Radiography are non-discriminatory with respect to any legally protected status such as race, color, religion, gender, age, disability, and national origin, and any other protected class. Disabilities that are not related to bona fide occupational qualifications will not be considered as deterrents to selection of persons SPECIAL NOTE: A NON-REFUNDABLE $25 APPLICATION FEE MUST ACCOMPANY THIS APPLICATION. SEND A MONEY ORDER MADE PAYABLE TO SRHS SCHOOL OF RADIOGRAPHY. CASH OR PERSONAL CHECKS ARE NOT ACCEPTABLE.

Please submit applications with transcripts and references to the school of radiography

(PLEASE PRINT RESPONSES)	RESPONSE
1. Date of Application	
2. Social Security Number	
3. Present Name (Last, First, Middle)	
4. Name used on all Transcript(s)	
5. E-Mail Address **(please print carefully)**	
6. Home Address (Street/Road, City, State, Zip)	
7. Contact - Phone numbers NOTE: Please circle the number which represents the best method to contact you during the daylight hours.	• ____________ Cell • ____________ Home • ____________ Work

8. Person to be notified in case of emergency:

Name: ________________________________ Relationship: _______________

Telephone #: ___________________

Cell Telephone #: ___________________

Address: ____

____

____

9. If you are attending or have attended a radiography school, give the following:

Name of School:

____

Address:

____

Program Director's Name: ____

Date of Entrance: ______________________________________

Date Withdrew: ____

Reason for Leaving:

____

You must submit a transcript from the above school.

When do you desire to enter our radiography program?

____

10. How did you learn about the Sharon Regional Health System **School of Radiography**?

	Check area(s) below	Provide contact information if possible
Previous Graduate		
Current Student		
High School Counselor		
College or Career Fair		
College or University		
Newspaper Ad		
Other (list source)		

If you have been convicted of a felony or misdemeanor (special emphasis to a crime of moral turpitude), read the following statement very carefully:

The Board of Trustees for The American Registry of Radiologic Technologists (ARRT) specifies that applicants for certification by the ARRT may be denied a certification or privilege of sitting for the registry examination if they have been convicted of a felony or misdemeanor (especially that regarding a crime of moral turpitude). Personal concerns regarding this position should be directed to the ARRT. They can be reached by going to www.arrt.org or telephone number (651) 687-0048, before completing this application. You will be directed to complete the Ethics Pre-application Review which is reserved for those who:

- Are not enrolled in an ARRT-recognized education program, or
- Are more than six months until graduating from an ARRT-recognized education program?

DECLARATION STATEMENT:

I ____________________________, hereby apply for entrance into SRHS School of Radiography. I agree to make myself available for interviews in regard to this application. I understand that I have the burden of producing adequate information for proper evaluation of this application and failure to produce adequate information in the prescribed timeframe will prevent the application from being evaluated or acted upon.

In filing this application, I declare the answers are true and understand that misrepresentation or omission of the facts whether intentional or not, shall be sufficient cause for automatic and immediate rejection of this application. In the event that approval has been granted prior to the discovery of such misrepresentation or omission, such discovery may result in reversal of the approval decision.

I hereby authorize SRHS School of Radiography and its designees to make whatever inquiries it deems necessary of any person or organization that is not a consumer-reporting agency to verify any of the information given in this application. I have the responsibility to keep this application current by informing the School of Radiography, through the Program Director, of any change in the area of inquiry. I specifically authorize the School of Radiography to consult any third party who may have information, including otherwise privileged or confidential information bearing on my qualifications, credentials, competence, character, or any matter bearing on satisfactorily meeting criteria for acceptance into Sharon Regional Health System, School of Radiography.

Date: ______________________

Signature: ____

Print Name: ____

Parent/ Guardian Signature: ___________________________________

(If under 18 years of age)

SHARON REGIONAL HEALTH SYSTEM
SCHOOL OF RADIOGRAPHY

LETTERS OF REFERENCE:
You must provide three letters of reference:
(We recommend an Academic, Employment and Professional Reference)

1. ____ Phone: ____________________
Academic Reference
2. ____ Phone: ____________________
Employment / Professional Reference
3. ____ Phone: ____________________
Employment / Professional Reference

Secondary Education: List all high schools or other secondary schools attended.

Dates From – To	Name of School	City and State	Diploma Received

Post-Secondary Education: List all formal education beyond high school.

Dates From – To	Name of School	City and State	Diploma Received

Regarding your Education – Which Course (s) did you like best and Why?

____

____

____

Regarding your Education – Which Course(s) did you like the least and Why?

____

____

Did your grades represent your best achievements or could you have done better? (Please explain)

____

____

List any extra-curricular activities, achievements, and / or honors that you believe might further qualify you for this Program:

Employment: List all work experience (full and part time), beginning with most recent

Dates From – To	Title of Position	Employer	City and State

What do you (or did you) like best about your most recent position?

____

____

What do you (or did you) like least about your most recent position?

____

____

ADDITIONAL DATA

List (3) things you have done that you are most proud of (work or non-work) and why?

1.

2.

3.

What appeals to you about working in the health care field?

What plans do you have for your future?

What have you already done to make these plans work out?

What are you currently planning to do to see that these plans work out?

What do you consider to be your personal strengths?

What is your typical way of dealing with conflict? Give an example

What hobbies or recreational interests are you involved in?

List any civic or community activities and offices held?

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SCHOOL OF RADIOGRAPHY

TECHNICAL STANDARDS

In Accordance with Section 504 of the 1973 Vocational Rehabilitation Act and the Americans with Disabilities Act (PL-101-336), the School of Radiography at Sharon Regional Health System has established a set of program technical standards relative to its education curriculum. While technical standards are not admission criteria, they are standards; which are necessary for successful completion of the clinical portion of the program and the practice of the profession.

Technical Standards	Able to Meet Standard	Unable to fully meet standard
1. Must be able to help in lifting and transferring patients who may be comatose, paralyzed or incapacitated		
2. Must have sufficient motor skills to be able to lift, move and push heavy equipment. Must be able to reach overhead		
3. Must be able to hear faint signals such as low sounding buzzers and bells to determine and recognize equipment malfunctions		
4. Must be able determine differences in gradual changes in blacks, grays and white for purposes of judging technical quality of images		
5. Must be able to communicate orally and in writing, instruction and directions to patients, and other personnel. Obtain health history and other pertinent data from patients		
6. Must be able to maneuver patients in wheelchairs, carts and imaging tables without injury to patient self or other health care workers and respond to medical emergencies		
7. Must have the manual dexterity, good motor skills, hand-eye coordination skills and sensory function to perform skills such as filling a syringe, putting on sterile gloves, assist with sterile procedures, maneuver equipment. Must be able to move patient and table to align body part and palpate bony prominences to align body part with image receptor		
8. Must have the cognitive ability to perceive and deal appropriately with environmental threats and stresses and continue to function safely and effectively in high stress periods		

Option 1: I have read and understand these technical standards. To be best of knowledge, I currently have the ability to fully meet these standards.

____________________________ ____________________________ ______________

Students name (Print) Student Signature Date

Option 2: I have read these Technical Standards and to the best of my knowledge, I am currently unable to fully meet the items indicated without accommodations. I am requesting the following accommodation.

____

____________________________ ____________________________ ______________

Students name (Print) Student Signature Date

These technical standards are provided for informational purposes only in order to better describe typical requirements of the profession, and in no way constitute an entrance requirement for the program. Students who identify potential difficulties with meeting the technical standards listed above will be encouraged to request auxiliary aid. Determination is made on an individual basis as to whether or not an accommodation or modification can be reasonably made. SRHS makes no pre-admission inquiries concerning an applicant's disabling condition, and does not discriminate against individuals on the basis of physical or mental disability.

SHARON REGIONAL HEALTH SYSTEM
SCHOOL OF RADIOGRAPHY

GUIDANCE COUNSELOR (High School) FORM

Dear Guidance Counselor:

Please indicate the following for ____
(Applicant Name)

If Applicable (Maiden Name) ____

Q.P.A. _________________(Example: 4.0, 3.5. 2.5. etc.)

COURSE		
Algebra I	Did Not Take	Passed with a C or Better; Yes No
Algebra II	Did Not Take	Passed with a C or Better; Yes No
Biology	Did Not Take	Passed with a C or Better; Yes No
Chemistry	Did Not Take	Passed with a C or Better; Yes No

SAT/ACT scores ___________________________

Name of High School: ____

Guidance Counselor' Name: ____
(Please print name)

High School Phone Number: ____

Signature: ____Date: ______________

Please send this form filled out along with a copy of the applicant's original transcript to:
School of Radiography
Sharon Regional Health System
740 East State Street
Sharon, Pennsylvania 16146
Deadline is January 31

SHARON REGIONAL HEALTH SYSTEM
SCHOOL OF RADIOGRAPHY

Have you included and or completed the following?

1. High school transcript(s) with official seal
2. College transcript(s) with official seal
3. 3 reference letters in sealed envelope(s)
4. SAT/ACT scores if taken
5. Completed application with $25.00 fee (MONEY ORDER ONLY see below)
6. Signed Technical Standards form
7. **ACCUPLACER Exam** – This Exam is scheduled and taken at the Butler Community College, BC3 – at LindenPointe Campus in Hermitage, PA. Their phone number is 724-346-2073. The Cost of the exam is $30.00. It is your responsibility to be sure your score is a part of the application process in which you are applying.
    - Please, see the School's website if you want more information and minimum scores required.
    - If you have taken the Accuplacer test in the previous year, your score can be used with your application. Please be sure to provide the date and place that you took the test.
    - Be sure to include a copy of the official test results with your application.
    - NOTE: Failure to include a copy of your official score and the information at the bottom will result in your application being seen as incomplete and you will not be eligible to continue with the application process.

Date you previously took the Accuplacer Test ____________________

Test site in which you took the test _____________________________

Name utilized when you took the test ___________________________

Social Security Number ______________________________________

Mail all information to:
SHARON REGIONAL HEALTH SYSTEM
SCHOOL OF RADIOGRAPHY
740 EAST STATE ST,
SHARON, PENNSYLVANIA 16146

SPECIAL NOTE: A NON-REFUNDABLE $25 APPLICATION FEE MUST ACCOMPANY THIS APPLICATION.
SEND A MONEY ORDER (**CASH AND PERSONAL CHECKS ARE NOT ACCEPTED**)

MONEY ORDER MAKE PAYABLE TO: **SRHS SCHOOL OF RADIOGRAPHY**
>PLEASE SUBMIT COMPLETED APPLICATION WITH SEALED OFFICIAL TRANSCRIPTS AND SEALED LETTERS OF REFERENCES.

Please call this school with any questions.