

Application for Admission



Rockford Memorial Hospital School of Radiography

Name: _____
Last First Middle Maiden

Address: _____
Number and Street City State Zip

Phone: _____

Email Address: _____

When would you like to enter this program? _____

Education:

High School _____
Name of School Date of Graduation

Additional Education _____
Name of School Dates of Attendance

Diploma or Degree Received: _____

If course not completed, state reason: _____

If you have attended any school of Radiography, please provide the following information:

Name City and State

Dates attended _____

Reason for leaving _____



List 2 references

1. _____

2. _____

These persons should be contacted by you and asked to send a personal letter of reference to:

Program Director
School of Radiography
Rockford Memorial Hospital
2400 N. Rockton Avenue
Rockford, Illinois 61103

Rockford Memorial Hospital School of Radiography has defined non-academic standards or Technical Standards to which all applicants must comply in order to be ABLE to participate and complete our Radiography Program. They are instituted not only for your protection but the protection of the patients, they are as follows:

The student **MUST** be able to:

- Communicate verbally and audibly with patients and staff;
- Maneuver all radiographic equipment used in the art and science of radiography;
- Visually inspect requests and images to evaluate the image for quality and positioning;
- Participate in the academic setting using both verbal and written English formats;
- Assist patients in transferring and/or ambulation from wheelchairs, carts, and beds.

Every effort will be made to accommodate a disability.

If a student radiographer develops a health problem that will prevent them from adhering to the health standards policy, he/she must notify the program director. A student may continue in the program with written permission from their physician, and as long as he/she fulfill the responsibilities and objectives of this policy and objectives of this policy and of the program. The student will be evaluated on the contents of this policy on their health examination before entering the program.

My signature below signifies I have read and that I comply with the above Technical Standards Policy.

Student Signature

Date

Please remit with \$15 application fee.
Rockford Memorial Hospital
School of Radiography
2400 N. Rockton Avenue
Rockford, Illinois 61103
815-971-5480