Aurora St. Luke's Medical Center®
of Aurora Health Care Metro, Inc.

School of Radiologic Technology

ADMISSION APPLICATION FORM

Please answer all questions completely

A $25.00 non-refundable fee is required at the time of application. Checks should be addressed to Aurora St. Luke's Medical Center.

Non-Discrimination Policy: Advocate Aurora Health is committed to upholding all federal and state laws that preclude discrimination on the basis of race, gender, age, religion, national origin, marital status, sexual orientation, disabilities, or veteran's status.

Applicant Information

Full legal name (including middle name):

Other name(s) that may appear on your academic records (if applicable):

Email:

Current Mailing Address:

Primary phone (include area code):

Last 4 digits of your social security number:

Will you be 18 years of age at the start of the program? Yes ☐ No ☐

Are you a U.S. citizen or do you have legal authorization to reside in the U.S.? Yes ☐ No ☐

Transcripts

To verify completion of pre-requisites, **official sealed** academic transcripts must validate all educational information provided. Transcripts must be sent directly **from the educational institute** postmarked by the application deadline to the address below. Hand carried transcripts will **not** be accepted.

Aurora Health Care
Attn: Radiology Program Supervisor
3031 W. Montana Street
Suite F North
Milwaukee, WI 53215

Education

List all post-secondary education institutions you have attended in the table below, in chronological order

	Name of School	Location	Dates Attended	Year Graduated
Junior/Technical College (if applicable)				
Other Post-Secondary Institution				
Other Post-Secondary Institution				
Other Post-Secondary Institution				
Other Post-Secondary Institution				
Other Post-Secondary Institution				

Employment History

List most current, first

Employer	Position Held	Dates Employed

Previous Health Care Experience

Do not include shadowing experience

Institution	Department	Dates

References

Please list 3 references: (teachers, TA's, employers; do not include friends or relatives)

Name	Address (City, State, Zip Code)

Prerequisite Coursework

All required pre-requisites must be completed and a plan in place to finish all courses prior to the start of the program. Indicate the term (example: FA22) for any in-progress or planned courses for the spring or summer. Indicate a grade of TBD (to-be-determined) for any incomplete courses. *Note: this information must match your official transcripts.*

Required Courses	Date Completed (Month/Year)	Institution	Grade
Anatomy & Physiology			
Medical Terminology			
College Algebra			

Job Shadow Experience

Shadowing opportunities may still be limited for the FA21 application cycle based on COVID restrictions. Applicants may select one of the following options to meet the requirement:

1. Arrange an in-person shadowing experience (4 hours minimum) with a hospital or medical center. Applicants must submit a **Job Shadow Verification Form** with their application.
2. View the alternative video compilation in lieu of in-person shadowing. Applicants must submit the **Job Shadow Requirement 2021 Form** with their application.

Date Completed (Month/Year)	Institution	Hours Spent

Other Certificates (CPR, CNA, etc.…)

Please attach a copy of the certificate for verification

Date Completed (Month/Year)	Institution

Information Session Attendance – Month/Year (if applicable):

Background Check, Drug Testing and Physical Exam

Upon acceptance to the program, all students must submit to a criminal background check, drug screening, and physical exam. Failure or refusal to submit the required testing will result in an incomplete application. Acceptance to the program will be rescinded.

All license and registry agencies have eligibility standards for their applicants. These standards address the question of an applicant's conviction of a felony or misdemeanor. The student is responsible for ensuring their license/registry eligibility.

For questions regarding eligibility, contact: The American Registry of Radiologic Technologists; www.arrt.org.

Applicant Signature

I acknowledge that the information I have supplied in this application is correct and understand that any falsification of information on this form may be cause for rejection as an applicant. If admitted, I agree to abide by the school's policies including, but not limited to, those contained in the Student Handbook and this application. I acknowledge that all submitted official transcripts will become property of the school and will not be forwarded to another institution or returned to me. Typing my name acknowledges my E-signature.

Signature: **Date:**