

Is there anything else you would like us to know about you? (Use a separate sheet if needed)

On a separate sheet of paper, explain why you are interested in this program and why you selected this institution. State your future goals, and why you are interested in this field of allied health.

EDUCATION

(Original transcripts must be sent directly to the program from every school you have attended, high school and above)

Name and Location of School or University	Dates Attended	Major Area of Study	Degree(s) Attained

All schools you have attended must be listed. Please Use a separate sheet if necessary.

Occupational, Professional Licenses, and/or Registry:

Type _____ Number _____

Date Obtained _____ Renewal Date _____

If Pending, What Type _____ Date _____

EMPLOYMENT HISTORY
(List most recent first)

Job Title	Dates of Employment	Reason for Leaving
Firm Name	Address	City State & Zip
Kind of Business	Briefly Describe Duties	
Immediate Supervisor's Name	Telephone	Hours Worked/Week

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CHARACTER REFERENCES

**Three personal references are required. References must be returned directly to the school by the evaluator
One reference must be from a recent employer or supervisor. Family or friends MAY NOT be used!**

Name	Address	Position
1.	_____	
2.	_____	
3.	_____	

The School of Technological Radiology is open to all qualified applicants without regard to political affiliation, race, color, religion, gender, age, disability, material status, place of birth or national origin with proper regard to their privacy and constitutional rights as citizens or legal residents.

Applicant's Statement

By signing below, I indicate that the information included on this application is true and correct to best of my knowledge. I understand that I may be dismissed from the Program if it is discovered that false information was given.

_____	_____
Applicants Signature	Date

A \$25 check or money order must be included with this application (application fee) payable to Jackson Memorial Hospital.

All application materials and correspondence should be mailed to:

Jackson Memorial Hospital
School of Technological Radiology
1500 NW 12th Avenue, Room 711
Miami, FL 33136-1096

(For School Use Only)

Application Received: _____ Application Fee Received: _____

Transcripts: High School _____ College _____ Foreign Education Evaluation _____ Other _____

Reference: #1 _____ #2 _____ #3 _____

Entrance Examination Score: _____ Personal Interview: _____ Medical Clearance: _____

_____ Accepted _____ Not Accepted Alternate # _____

Comments: