

**Radiography Program
Application**

Directives

- 1.) Please fill out the application digitally, save the completed PDF and e-mail it to the program director, Stacey O'Brien, at sobrie28@jhmi.edu.
- 2.) Mail the application fee of **\$40.00** in the form of a check or money order made out to **The Johns Hopkins Hospital to the address listed in the top-left corner of this document. Cash payment will not be accepted.** *Applications will not be reviewed until the application fee has been received.*
- 3.) **Digitally release all college or professional program transcripts** directly to the Johns Hopkins Schools of Medical Imaging to the program director, Stacey O'Brien, at sobrie28@jhmi.edu.
- 4.) Request recommendation forms. Completed recommendation forms must be **e-mailed directly from the referrer** to the program director, Stacey O'Brien at sobrie28@jhmi.edu.

Personal Data

Name: _____
Last First Middle

Preferred Name: _____ **Pronouns:** _____

Current Address:

Street Address

City State Zip Code

Permanent Address:

Street Address

City State Zip Code

E-Mail Address: _____ **Phone Number:** _____

To be eligible for this program, applicants must be 18 years or older.

Will you be 18 years of age on or prior to the start of the program? YES NO

To be eligible to apply to this program, applicants must be United States citizens or have permanent residence.

Are you a United States citizen? YES NO

If NO, do you have a Permanent Resident Card? YES NO

Education Data

To be eligible for this program, applicants must be either a currently enrolled university affiliate student or have earned, at minimum, an associate degree by the program start date.

Are you a currently enrolled university affiliate student? YES NO

If YES, please indicate the university affiliate in which you are currently enrolled:

- | | |
|---|--|
| <input type="checkbox"/> Anne Arundel Community College | <input type="checkbox"/> Immaculata University |
| <input type="checkbox"/> Commonwealth University | <input type="checkbox"/> Millersville University |
| <input type="checkbox"/> Carroll Community College | <input type="checkbox"/> Montgomery College |
| <input type="checkbox"/> College of Southern Maryland | <input type="checkbox"/> Notre Dame of Maryland University |
| <input type="checkbox"/> Harford Community College | <input type="checkbox"/> York College of Pennsylvania |

Degree College/University: _____

Date degree received/expected (month/year): _____

Please list any colleges/universities/professional schools attended, starting with the most recent:

College/University/Professional School	Location	Years Attended (From / To)	Graduate	Degree/Diploma/Certification Awarded
		/	<input type="checkbox"/> YES <input type="checkbox"/> NO	
		/	<input type="checkbox"/> YES <input type="checkbox"/> NO	
		/	<input type="checkbox"/> YES <input type="checkbox"/> NO	
		/	<input type="checkbox"/> YES <input type="checkbox"/> NO	
		/	<input type="checkbox"/> YES <input type="checkbox"/> NO	

If any academic transcripts are under a different name, please provide that name here:

List any held professional certifications and/or licenses (e.g., CNA, CNMT, EMT, RN, RT, etc.):

Professional Certification/License	Number	Effective Date

All prerequisite coursework must be completed before the start of the program:

Course	Semester Completed or Enrolled
Human Anatomy & Physiology I (4 credits, with laboratory)	
Human Anatomy & Physiology II (4 credits, with laboratory)	
Medical Terminology (3 credits)	
College Algebra (3 credits)	
English Composition (3 credits)	
At least one of the following:	
Public Speaking (3 credits)	
Interpersonal Communication (3 credits)	

Employment Data

List all employers for the last five years, starting with the most recent:

Employer	Employer Address	Position Title	Time Employed (From / To)
			/
			/
			/
			/
			/

Describe any volunteer work completed:

Recommendation Forms

The Johns Hopkins Hospital Schools of Medical Imaging requires that applicants provide recommendation forms from one professor of a prerequisite science course and one Recommendation Form from a current supervisor. *Only the provided recommendation form will be accepted. If unable to provide recommendation forms as required, e-mail the program director, Stacey O'Brien.*

Attestation

I hereby certify that the statements set forth in the above application are true and complete to the best of my knowledge. I understand that, if accepted, falsified statements on this application will be considered sufficient cause for dismissal from the program.

I also understand that admission into the program implies my agreement to adhere to all hospital and program policies and regulations.

If selected for the program, I agree to submit to a background check and pre-employment physical, including a drug screening, administered by the occupational health department of The Johns Hopkins Hospital prior to beginning the program.

Signature: _____ **Date:** _____

If applicable, indicate all other programs at the Johns Hopkins Hospital Schools of Medical Imaging that you are applying to below:

- Diagnostic Medical Sonography
- Nuclear Medicine Technology Program

How did you hear about the Johns Hopkins Hospital Schools of Medical Imaging?

The Johns Hopkins Schools of Medical Imaging does not discriminate on the basis of: race, color, ancestry or national origin, immigration status, ethnicity, age, disability, religion, sex, gender, pregnancy, military status, veteran status, marital status, sexual orientation, gender identity or expression, genetic information, and other legally protected characteristics.