



# OHIO VALLEY MEDICAL CENTER

2000 Eoff Street  
Wheeling, WV 26003

Dear Candidate for Admission,

Requirements and necessary forms for admission to the Ohio Valley Medical Center Program of Radiologic Technology are included in this packet. Listed below are the items that must be sent to the program in order to ensure application processing is not hindered.

- \_\_\_\_\_ 1. Application
- \_\_\_\_\_ 2. Application fee, twenty-five (\$25.00)
- \_\_\_\_\_ 3. Official high school transcript
- \_\_\_\_\_ 4. Official college transcript
- \_\_\_\_\_ 5. ACT and/or SAT score
- \_\_\_\_\_ 6. Three (3) letters of recommendation

Once these items are received and it is determined you meet all admission criteria outlined in the enclosed brochure, you will be contacted regarding an observation day appointment. If you have not been contacted within three (3) weeks following application submission, please contact the program

If all items are not received, the application will be considered incomplete and will not be processed. Required information and the observation must be completed by November 15 to be considered for a position in the class beginning the following July.

We appreciate your interest in the profession of radiologic technology at the Ohio Valley Medical Center. If you have any questions or concerns, please contact me at (304) 234-8781.

Sincerely,

Catherine M. Ball, M.S., R.T. (R) (M)  
Program Director

# OHIO VALLEY MEDICAL CENTER

## PROGRAM OF RADIOLOGIC TECHNOLOGY APPLICATION FOR ADMISSION

**PLEASE PRINT ALL INFORMATION**

**APPLICATION FEE:** Please include a \$25.00 check or money order made payable to:  
OVMC Program of Radiologic Technology

**REQUEST FOR EARLY ADMISSION DECISION:** Please check appropriate box \* *yes* \* *no*  
*Guidelines for early admission decision are listed in brochure*

PERSONAL DATA			
The Ohio Valley Medical Center Program of Radiologic Technology does not discriminate on the basis of race, color, religion, sex, national origin, ancestry or disability. The Age Discrimination Act of 1967 prohibits discrimination on the basis of age. None of the information requested below will be used for any unlawful purposes.			
<b>NAME</b>	_____	<b>DATE</b>	_____
	Last                      First                      Middle		
<b>ADDRESS</b>	_____		
	Street Address	City/Town	State                      Zip Code
<b>SOCIAL SECURITY NUMBER</b>	_____	<b>PHONE NUMBER</b>	_____
Have you ever applied to this program before? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, when? _____			
Is there any other name that may be pertinent when checking work and personal references? _____			

**THE SECTION BELOW IS FOR OFFICE USE ONLY – DO NOT COMPLETE**

APPLICATION DATES	COMPLETE FOLLOWING ACCEPTANCE
Date received _____ <input type="checkbox"/> Check/Money Order <input type="checkbox"/> Cash	Date of Physical _____    Date of Birth _____
Transcripts received <input type="checkbox"/> High School <input type="checkbox"/> College	Start Date _____    Graduation Date _____
References received <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>In Case of Emergency, please notify</b>
Date observed _____	Name _____
Volunteered <input type="checkbox"/> Yes <input type="checkbox"/> No	Address _____
	Phone Number _____

**EDUCATION**

**HIGH SCHOOL** \_\_\_\_\_

NAME

DID YOU GRADUATE?  YES  NO

GED  YES  NO

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY or TOWN

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

MAJOR COURSES OF STUDY \_\_\_\_\_  
\_\_\_\_\_

**COLLEGE** \_\_\_\_\_

NAME

DID YOU GRADUATE?  YES  NO

GED  YES  NO

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY or TOWN

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

MAJOR COURSES OF STUDY \_\_\_\_\_  
\_\_\_\_\_

**OTHER** \_\_\_\_\_

NAME

DID YOU GRADUATE?  YES  NO

GED  YES  NO

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY or TOWN

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

MAJOR COURSES OF STUDY \_\_\_\_\_  
\_\_\_\_\_

**MILITARY**

**BRANCH OF SERVICE** \_\_\_\_\_

**MILITARY SPECIALTY** \_\_\_\_\_

**RESERVE STATUS/NATIONAL GUARD** \_\_\_\_\_

**WORK EXPERIENCE**

**\*\* Please list all work experience – most recent first \*\***

<b>EMPLOYER</b>	<b>POSITION HELD</b>	<b>PHONE NUMBER</b>	<b>HOURS PER WEEK</b>	<b>FROM MO./YR.</b>	<b>TO MO./YR.</b>

**VOLUNTEER EXPERIENCE**

**\*\* Please list all volunteer experience – most recent first \*\***

<b>EMPLOYER</b>	<b>POSITION HELD</b>	<b>PHONE NUMBER</b>	<b>HOURS PER WEEK</b>	<b>FROM MO./YR.</b>	<b>TO MO./YR.</b>

**PLEASE READ CAREFULLY AND RESPOND**

If you have had a felony or misdemeanor conviction with the sole exception of speeding and parking violations, in the past ten years, the American Registry of Radiologic Technologists reserves the right to determine if you will be permitted to sit for the Certification Examination, even if you have completed all graduation requirements.

In accordance with this requirement for certification, please respond to the following question.  
Have you been convicted of a crime, including a felony or misdemeanor with the past ten (10) years?

**Yes**     **No**    If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*\* The American Registry of Radiologic Technologists can be reached at (651) 687-0048 or [www.asrt.org](http://www.asrt.org)

**PLEASE READ CAREFULLY AND SIGN BELOW**

I hereby certify the facts set forth in this application of Admission are true and complete to the best of my knowledge. I understand falsified statements on this application shall be considered sufficient cause for dismissal. You are hereby authorized to fully investigate all such information. I hereby release from all liability or damages, those persons, agencies and organizations that may furnish information in connection with my application for admission.

I acknowledge that following acceptance I will be required to take and pass an admission physical. The admission physical is provided by Ohio Valley Medical Center and conducted by a licensed physician. This examination shall include, but will not be limited to, laboratory tests, drug and alcohol testing, tuberculin skin test, chest x-ray, immunization history and communicable disease history. If the admission physical reveals that I will not be able to perform the essential requirements of a student enrolled in the Ohio Valley Medical Center Program of Radiologic Technology with reasonable accommodations, the acceptance offer will be withdrawn.

I understand my completion of this application does not guarantee my consideration for admission, nor does its completion in any way commit the Ohio Valley Medical Center Program of Radiologic Technology to admit me as a student.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**PLEASE MAIL COMPLETED APPLICATION AND FEE TO:**

Program Director  
Ohio Valley Medical Center  
Program of Radiologic Technology  
2000 Eoff Street  
Wheeling, West Virginia

\*\*\* Please have **official transcripts** and **ACT scores** forwarded to the above address \*\*\*