OHIO VALLEY MEDICAL CENTER
PROGRAM OF RADIOLOGIC TECHNOLOGY
ADMISSION REFERENCE FORM

SECTION 1 TO BE COMPLETED BY APPLICANT
PRINT CLEARLY

Name of Applicant:_________________________________________________
(Last)                                       (First)                                 (Middle)

Please Note: Federal Law requires that all reference and placement materials be
open for inspection
Upon student request.

• I waive the right to see this reference____________________________________
(Signature of Applicant)                             (Date)

• I retain the right to see this reference____________________________________
(Signature of Applicant)                            (Date)

Name of Reference_________________________________________________

Address of Reference_________________________________________________
(Street)                   (City or Town)                  (State)            (Zip)

Place of Business_______________________________________________

Phone Number_(______)______ -__________
The applicant listed above is requesting admission to the Program of Radiologic Technology at the Ohio Valley Medical Center and has listed you as a personal reference. Please briefly respond to the following questions. Your cooperation in completing and promptly returning this form will assist both the applicant and the Program of Radiologic Technology.

1) How long have you known the applicant?
   ________________________________________________

2) In what capacity do you know the applicant? (i.e. professionally, personally)
   ________________________________________________
   ________________________________________________
   ________________________________________________

3) Do you consider the applicant’s achievements thus far to be a true indicator of his/her ability?
   ________________________________________________
   ________________________________________________
   ________________________________________________

4) What are the applicant’s principle weaknesses, if applicable?
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________

5) What are the applicant’s principle strengths, if applicable?
   ________________________________________________
   ________________________________________________
6) What is your estimation of the applicant's success in the field of Radiologic Technology?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

7) Please include additional comments you wish to make regarding this applicant (character, interpersonal relationships, achievements, etc.)

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Reference Signature: ___________________________ Date: / / 

Applicant's credentials will not be evaluated for admission until all references are submitted. Please return this form prior to November 15 to:

Program of Radiologic Technology
Ohio Valley Medical Center
2000 Eoff Street
Wheeling, West Virginia 26003

1997, Rev. 11/02, 09/05

Official Use: Date sent to reference: ______Date received from reference: _____