Instructions for Completing the Application

The deadline for submitting applications is June 1, 2020.

Please check each item completed:

☐ 1. Complete the enclosed application. An incomplete application will not be considered.

☐ 2. An OFFICIAL ACT composite score of 19 or above is a requirement. NO EXCEPTIONS.

☐ 3. Include an official high school transcript. (If you have a GED, we will require your high school transcripts and your GED scores.) These should be in a sealed envelope from the school.

☐ 4. Include official transcripts of all colleges, universities or other post-secondary training programs, and attach all OFFICIAL transcripts to the application. These should be in a sealed envelope from the school. (See degree requirements in catalog.)

☐ 5. A cumulative GPA of 2.0 is required.

☐ 6. You must have the three enclosed reference forms completed and mailed to the school (only three reference forms, no letters accepted). Sources may be the same as references listed on the application. You should have known these references for at least one (1) year. (Exclude family.)

☐ 7. Have you applied to this school before? □ Yes □ No
   If “yes,” what year did you apply? __________________________________________________________

☐ 8. Have you applied to another program of radiologic technology this year or in the past? □ Yes □ No
   If “yes,” which schools? ________________________________________________________________

☐ 9. I will be 18 years of age or older by September 1, 2020. □ Yes □ No

☐ 10. Have you ever been charged with or convicted of a felony or misdemeanor? □ Yes □ No

☐ 11. After completing the application, mail it to the following address, along with the application fee of $40. Make check payable to “North Oaks Medical Center.” (This is non-refundable) Mail to: North Oaks School of Radiologic Technology, P.O. Box 2668, Hammond, LA 70404.

After the school receives your application, you will be notified of the date and time of your interview. If you have any questions or would like to set up an appointment, please call Program Director Marsha J. Talbert, M.S., R.T. (R), at (985) 230-7805.

Please return this completed form. Do not fold application.
Personal Information:

Social Security Number:_______-____-_______

Name:_____________________________________________________________________________________________________

Last First Middle Maiden

Street:_____________________________________________________________________________________________________

City: ____________________________________________________________  State: _____________  Zip: _________________

Email: _____________________________________________________________________________________________________

Home Phone #: (_____)____________________________  Work Phone #: (_____)____________________________

Cell Phone #: (_____)____________________________  Other Contact #: (_____)________________________________

No person will be discriminated against because of race, color, national origin, age, sex, religion or handicap.

Education: List ALL schools attended.

<table>
<thead>
<tr>
<th>Name and Location of School</th>
<th>Dates Attended</th>
<th>Graduation Date</th>
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<tbody>
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<td>High School:</td>
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<td>College:</td>
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<td>Other:</td>
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Note: If you have attained a college degree, please specify.
Employment - List all work experience beginning with the most recent.

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Title/Duties</th>
<th>Reason for Leaving</th>
<th>City and State</th>
<th>Dates</th>
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</table>

I have volunteered or observed in an imaging department. _____YES _____NO _____# of hours
Where?: ________________________________________________________________

References: List below the names of three persons whom you have known at least one (1) year.
(Exclude family.)

1. Name: ____________________________________________________________ Years Acquainted: _________
   Address: ___________________________________________ Phone #: (_____) __________________________
   City, State, Zip: ______________________________________________
   Business: _______________________________________________________

2. Name: ____________________________________________________________ Years Acquainted: _________
   Address: ___________________________________________ Phone #: (_____) __________________________
   City, State, Zip: ______________________________________________
   Business: _______________________________________________________

3. Name: ____________________________________________________________ Years Acquainted: _________
   Address: ___________________________________________ Phone #: (_____) __________________________
   City, State, Zip: ______________________________________________
   Business: _______________________________________________________
Indicate below the reason(s) why you would like to enter the field of radiologic technology:

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I certify that the statements made by me in this application are true, complete and correct to the best of my knowledge and are made in good faith. I understand that any false statements or omissions made herein will void this application and, if accepted into the school, I may be subject to dismissal without notice at any time.

Signature: ___________________________________________ Date: _____/_____/_____

How did you hear about our program? _____ Friend/Family _____ School Counselor _____ Internet Search
_____ Newspaper Ad _____ Website _________________________
Other ____________________________