Application for Admission

This form must be printed or typed and all blanks completed.
If more space needed, add additional sheet(s).

SANFORD®

Sanford Medical Center
School of Radiologic Technology
1305 W 18th Street • PO Box 5039
Sioux Falls, SD 57117-5039

Have you applied previously to our program? ☐ Yes ☐ No When?

PERSONAL DATA

Last Name	First Name	Middle Name	
Mailing Address	City	State	Zip Code
Home Telephone Number ( ) -	Cell Phone Number ( ) -	Email Address	

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name	Relationship to Applicant	Telephone Number ( ) -	
Address	City	State	Zip Code

Grade Transcripts: It is the responsibility of the applicant to have official high school and college transcripts (to include the current semester) sent to us.

EDUCATION

High School	City, State, Zip Code	Last grade completed	Did you graduate? ☐ Yes ☐ No ☐ GED
College(s)/University(ies) Attended	City, State, Zip Code	Date of Attendance	Degree/Major

ACT EXAMINATION

Have you taken the ACT examination? ☐ Yes ☐ No ☐ If yes, when?	Did you have the results sent to Sanford Medical Center School of Radiologic Technology? ☐ Yes ☐ No If no, please have scores sent to our program from ACT directly or on high school/college transcript.

EMPLOYMENT HISTORY

Employer	City, State, Zip Code	Job Title
Supervisor Name and Title	Telephone Number ( ) -	May we contact? ☐ Yes ☐ No
Duties		Dates: (MM/YY to MM/YY) to

019058-00052 2/18

EMPLOYMENT HISTORY (cont.)

Employer		City, State, Zip Code	Job Title
Supervisor Name and Title		Telephone Number ( ) -	May we contact? ☐ Yes ☐ No
Duties			Dates: (MM/YY to MM/YY) to
Employer		City, State, Zip Code	Job Title
Supervisor Name and Title		Telephone Number ( ) -	May we contact? ☐ Yes ☐ No
Duties			Dates: (MM/YY to MM/YY) to

Please attach an additional sheet for additional work/volunteer experiences, if needed.

REFERENCES *(Reference suggestions: Teacher, coach, counselor, employer, clergy)*

Reference Name	Title	Email Address	
Street Address	City, State, Zip Code		Telephone Number ( ) -
Reference Name	Title	Email Address	
Street Address	City, State, Zip Code		Telephone Number ( ) -
Reference Name	Title	Email Address	
Street Address	City, State, Zip Code		Telephone Number ( ) -

APPLICATION FEE

For application completion, a non-refundable $35 application fee must be included with the application to be considered for an interview. Please make a check or money order for $35 payable to Sanford Medical Center School of Radiologic Technology.

IMPORTANT

The ARRT Registry Examination application asks if you have ever been convicted of a misdemeanor, felony or a similar offense in a military court-martial. If you have any eligibility concerns, in order to receive important information regarding registrant eligibility, **prior to seeking entrance to this or any radiography program**, contact the American Registry of Radiologic Technologists, 1255 Northland Drive, Mendota Heights, MN 55120.

I hereby affirm that all information contained in this application is true and complete and that any falsification shall be sufficient reason for rejection of my application or dismissal, if accepted into the radiologic technology program.

_____   _____
Applicant's Signature   **Date**

Note: The processing of this application will be accelerated by prompt receiving of the above specified information. When this has been accomplished, you will be contacted for a personal interview. The entire application process **MUST** be completed and received by the program by January 31st.

MAIL APPLICATION AND CREDENTIALS TO:
Sanford Medical Center
School of Radiologic Technology
Attn: Candace McNamara/Program Director
1305 W 18th Street, PO Box 5039
Sioux Falls, SD 57117-5039