

ADMISSION CRITERIA

1. Completed applications must contain the following:
 - A. Completed application form with the non-refundable fee.
Please make all checks payable to: DRMC Radiologic Technology Program.
 - B. An essay.
 - C. 3 letters of reference.
 - D. Official high school transcripts are required and college transcripts if applicable (sealed envelopes).
 - E. SAT and/or ACT Test scores if applicable.

(We ask that ALL information be sent in one packet in order to reduce processing time and errors.)
2. All information will be kept strictly confidential.
3. Applicants are selected in accordance with nondiscriminatory policies.
4. Permission is granted to consult previous educators, employers and agencies.
5. Fee schedules will be provided at the time of interviews.
6. Danville Regional Medical Center School of Health Professions Radiologic Technology Program will perform criminal background checks on all applicants; any false statements will be grounds for non-acceptance or dismissal.
7. Minimum admission/application educational requirements:
 - A. High School diploma or equivalent with:
 - ✓ A minimum cumulative GPA of 2.5.
 - ✓ Two units of the following high school math courses with a grade “C” or above:
 - Algebra I Algebra II or Geometry
 - ✓ Two units of the following high school science with a grade “C” or above:
 - Anatomy Biology Chemistry or Physics.
 - B. Before classes begin, those that have been accepted must also have successfully completed the following college level courses with a minimum final grade of “C” or better;
 - ✓ Human Anatomy & Physiology I
 - ✓ Medical Terminology I
 - C. Additional required general education courses which **MUST be completed prior to graduation;**
(Check with the Program Director for specific class information.)
 - ✓ College Success Skills (or equivalent)
 - ✓ English (College Composition I) (or equivalent)
 - ✓ MTH Elective (126 or higher) (or equivalent)
 - ✓ Humanities Elective
 - ✓ Social/Behavioral Science Elective

(All General Education Courses MUST be completed prior to graduation.)
8. Acceptance of students is a two part process based upon results of, Part 1. Completed application score and Part 2. Personal interview score. Each candidate’s application and transcripts will be reviewed with a score being obtained from academic grades in math, science and other relative courses. (Advanced/college prep courses will carry more weight than standard course work.) Based on these scores the most qualified individuals will be granted a personal interview. The interview scores will be added to the application score in order to make our final decisions.

- 9. Acceptance into the DRMC School of Health Professions Radiologic Technology Program is also contingent upon potential students passing a pre-enrollment drug screening and physical examination. Results of these tests are confidential and are maintained by the institution.**
- 10. Technical standards: Due to the nature of this profession and considering the safety of our patients and our students, applicants must be able to meet all of the following technical standards in order to be considered for enrollment.**
- A. Sufficient corrected eyesight to observe patients, manipulate equipment and evaluate radiographic quality.**
 - B. Sufficient corrected hearing to assess patient needs and communicate verbally with other healthcare providers.**
 - C. Sufficient verbal and written skills to communicate needs promptly and effectively in English.**
 - D. Sufficient gross and fine motor coordination to respond promptly, manipulate equipment, lift a minimum of 30 pounds and ensure patient safety.**
 - E. Intellectual and emotional functions needed to exercise independent judgment and discretion in the safe technical performance of medical imaging procedures.**

APPLICATION DUE BY JUNE 1st

- **This application must be accompanied by a non-refundable \$35 application fee (Checks or money orders only).**
 - **Please make checks or money orders payable to:**
 - **DRMC Radiologic Technology Program and**
 - **Include the applicants first and last name in the memo section of the check.**
 - **Please do not mail cash!**
 - **Mail to: DRMC Radiologic Technology Program
109 Bridge Street
Suite 200
Danville, VA 24541**
 - **In order to reduce delays and potential errors, please place all documents in a sealed envelope and mail as one complete packet.**
- **Applicants are selected in accordance with non-discriminatory policies.**
- **Due to limited enrollment, applicants who meet all requirements are not guaranteed acceptance into this program, however, those who already have an Associate's Degree will be awarded additional points. Applicable College Prep, Honors and Advanced courses will also receive bonus points.**
- **Completely fill in all items on this application; type or print legibly.**

The Admissions Committee will review only applicant files that are **complete**. It is the applicant's responsibility to ensure that the school receives all required documentation. After selections have been made, all applicants will be notified whether selected, not selected, or placed on an alternate list. Selected applicants will be required to submit an admission fee; successfully complete any remaining prerequisite courses; undergo drug screening and criminal background check; submit a completed health assessment form, immunization record, and current CPR certification.

Title IX - Notice of Non-discrimination Policy

The *Danville Regional Medical Center School of Health Professions* does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities. Inquiries and/or concerns regarding the non-discrimination policies of *The School of Health Professions* may be addressed by contacting our Title IX Officer by phone or email @; 434-799-2271 or Mary.thomas1@lpnt.net. The Title IX Coordinator may also be reached by US Mail at Mary Thomas, **Title IX Coordinator, Radiologic Technology Program, 109 Bridge Street-Suite 200, Danville, VA 24541**. For further information, visit <http://wdcrobcolpo1.ed.gov/CFAPPS/OCR/contactus.cfm> for the address and phone number of the office that serves your area, or call 1-800-421-3481.

APPLICANT INFORMATION

All applicants MUST be 18 years of age no later than January 1 of the year of entry!

Name _____
Last First Middle Maiden

If different, include your last name as it appears on your High School and/or college transcript:

Mailing Address _____
Street City State ZIP Code

Telephone: Home () _____ Work () _____ Cell () _____

**Email Address: _____ Are you a U.S. citizen? Yes No

(This is our PRIMARY means of communicating with you. Please check email frequently!)**

In case of emergency call: _____

Phone Number: () _____ **Relationship** _____

APPLICANT INFORMATION

Have you ever been convicted of or are you presently under indictment for any felony or misdemeanor offense **other than** traffic violations?* Yes No If yes, please explain in an attached letter.

***Information is subject to verification through a REQUIRED Criminal History Background check.**

Attention Applicants: The Board of Health Professions and/or the American Registry of Radiologic Technologists “may refuse to admit a candidate to any examination, or may refuse to issue a license or certificate to any applicant” based on a number of both criminal and/or unprofessional conduct reasons. If there is any question, applicants may wish to complete the ARRT Ethics Review Pre-Application. This may be found on the ARRT web site at <https://www.arrt.org/pdfs/Ethics/Ethics-Review-Pre-Application.pdf>.

Do you have a mental, physical or chemical dependency condition, which could interfere with your current ability to practice in the healthcare field?

Yes No If you answered yes, please explain in detail on a separate sheet and attach to this application.

EMPLOYMENT HISTORY

Include all employment within the past five years, beginning with your present or last employment.

1. Employer _____
City/State _____ Dates Employed: From _____ To _____
Job Responsibilities _____
Reason for Leaving _____
2. Employer _____
City/State _____ Dates Employed: From _____ To _____
Job Responsibilities _____
Reason for Leaving _____

RECOMMENDATIONS/REFERENCES

Submit three (3) completed professional or academic recommendation/reference sheets (such as a recent employer, teacher, and/or counselor.), **NOT RELATIVES, FRIENDS, OR CLERGY**. Each person serving as a reference must complete the form, place it in an envelope, seal the envelope and sign across the back flap, and return the sealed envelope to you. Include these sealed envelopes with your application. References not meeting the above criteria are considered invalid.

STUDENT ESSAY

On a separate sheet, please write a brief essay addressing each of the following:

- Your experiences and activities including **awards/honors, volunteer or community service**
- Your reason for selecting this career and your reason for desiring to enter this school
- Your perception of your intellectual capability to complete this program
- Your plans and aspirations for the future
- Why do you think communication and critical thinking are important skills for a health professional to possess.

APPLICATION CHECK LIST (Things to be submitted)

- | | |
|---|--|
| <input type="checkbox"/> Completed Application | <input type="checkbox"/> Application Fee |
| <input type="checkbox"/> 3 Recommendations/References | <input type="checkbox"/> Essay |
| <input type="checkbox"/> High School Transcripts | <input type="checkbox"/> College Transcripts |

EDUCATION

Please request transcripts from each institution you attended and either send to us or include with application!

Do you have a high school diploma? Yes No If not, do you have a G.E.D.? Yes No

HIGH SCHOOL PRE-REQUISITE COURSES

These requirements MUST be met prior to application.

Please check all that apply: Two units of high school math with a grade “C” or above

Algebra I Algebra II Geometry

Two units of high school science with a grade “C” or above

Anatomy Biology Chemistry Physics

High School Attended _____

City/State _____ Graduation Date _____

List in chronological order all colleges, universities, and vocational/technical schools which you have attended. (Attach an additional sheet if needed!)

1. Name of School _____ City/State _____

Dates Attended: *From* _____ *To* _____ Graduation Date _____

Degree Obtained: _____

2. Name of School _____ City/State _____

Dates Attended: *From* _____ *To* _____ Graduation Date _____

Degree Obtained: _____

Have you previously attended or applied to this program? Yes No

Have you attended another school or program similar to this one? Yes No

If yes, what program and school did you attend? _____

Graduation Date: _____

COLLEGE LEVEL COURSES

Courses marked with an * **must be completed by end of Fall term prior to entry into the program**, these courses are not required prior to application. Please include “official transcripts” for these courses. However, **ALL** of the courses listed below **MUST be completed before graduation**. Please check with the Program Director @ (434)799-2271 before scheduling placement tests or enrolling in any general education courses!

Please indicate your current status in the following college courses.

Course # (or equivalent)	Course	Credit Hours	Currently Enrolled (Y or N)	Complete (Y or N)	College
SDV 100	College Success Skills	1			
*BIO 141	*Human Anatomy and Physiology I	4			
*HLT 143	*Medical Terminology I	3			
ENG 111	English Composition I	3			
HUM Elective	Humanities Elective	3			
MTH Elective	Mathematics Elective (MTH 126 or higher)	3			
SOC Elective	Social Science Elective	3			

LICENSE

Do you a license in another healthcare field? Yes No
 Have you ever applied for licensure or certification in Virginia or another state? Yes No
 If yes, and you took the licensing examination, give the date, and indicate whether or not you passed.

Exam: _____ State _____

Date(s) _____ Passed Yes No

Please check the appropriate box.

Has your license ever been:	Yes	No	N/A
Voluntarily surrendered to any licensing authority?			
Placed on probation?			
Suspended?			
Revoked?			
Otherwise disciplined?			
Have you ever been the subject of an investigation by any licensing board?			

If you answered yes to any of the above questions, explain in detail on a separate sheet and attach to this application.

DISCLOSER

CERTIFICATION, ACKNOWLEDGEMENT, AND AUTHORIZATION:

Please read the following statement carefully before signing.

I certify that the information contained in this application is true and complete. I understand that if I am found to have provided false or incomplete information on this application, the Program may cancel my application or, if I have been accepted, remove me from the Program.

I understand that if I am enrolled in the DRMC School of Health Professions, I will be subject to and required to abide by all of the School's policies, procedures, and practices, including (among others) their Program on Illegal Drugs and Alcohol. I agree that I will abide by these policies, procedures, and practices, including any that the School may add or modify during my enrollment.

I understand and acknowledge that the DRMC School of Health Professions has a legitimate need to know the details of my education and employment history in order to consider my application. I hereby authorize and request for my former schools, employers, and other institutions or persons with information about my education and employment history to provide to the DRMC School of Health Professions any information or records the School may request about my education or employment history. I hereby release from any liability of any kind any institution, company, or person who provides such information or records and any authorized representative of the School who requests such information or records.

(Note: The DRMC School of Health Professions is firmly committed to maintaining an environment free of the influence of illegal drugs and alcohol. The School maintains the right to require any student to undergo testing to determine his or her fitness for duty, such as to determine whether the student may pose a potential danger of harming patients or may have a medical problem that interferes with his or her ability to perform duties safely or effectively. In keeping with this practice, a student may be tested for drugs or alcohol to help determine that person's fitness for duty. For more information, please refer to the School of Health Professions Policy on Illegal Drugs and Alcohol.)

 Applicant's Signature

 Date

CONFIDENTIAL RECOMMENDATION/REFERENCE FORM

Section 1 (to be completed by applicant)

Indicate your decision regarding a waiver of the right of access before giving it to the person who will submit it. Give the form and a self-addressed and stamped referral envelope to the person making the recommendation. Have him or her place the completed recommendation into the envelope, seal it and sign across the seal. The envelope should be returned to you and you should return it with your application. Do not return separately.

Applicant's Name _____ <div style="display: flex; justify-content: space-between; width: 100%; margin-top: 5px;"> Last First M.I. </div>
--

The Family Educational Rights and Privacy Act of 1974 and its amendment's guarantee students access to their educational files and all information concerning them. Students are also permitted to waive their right of access to recommendations. The following signed statement is the applicant's wish regarding this recommendation.

<input type="checkbox"/> I waive my right to inspect the contents of the following recommendation. <input type="checkbox"/> I do not waive my right to inspect the contents of the following recommendation. _____ Applicant's Signature
--

This individual wishes you to write a letter of recommendation on behalf of his or her application to the DRMC School of Health Professions Radiologic Technology Program. Your objective evaluation of the applicant's qualifications would be most appreciated.

Section 2 (to be completed by the person making this recommendation)

Name of person making recommendation _____ <div style="display: flex; justify-content: space-between; width: 100%; margin-top: 5px;"> Last First M.I. </div>
--

How long and in what capacities have you known the applicant?

Please specify the group to which you are comparing this applicant:

- Other high school students
 Undergraduate college students
 Employees

Characteristic	Excellent Upper 10%	Good Upper 11- 20%	Average 21-59%	Below Average <60%	No Basis For Judgment
Overall intellectual ability					
Understanding fundamentals of chosen occupation					
Written communication skills					
Verbal communication skills					
Ability to organize and apply facts and ideas					
Manual dexterity					
Ability to handle stressful situations					
Aptitude for higher education					
Intellectual curiosity					
Motivation					
Potential as a health care provider					
Overall, How do you rate this applicant?					

We realize that check off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments regarding the potential of the applicant to be a health care practitioner including remarks concerning maturity, personality, extracurricular activities or any other factors that you feel are important concerning the applicant's aptitude for successful performance within the educational process and/or profession.

Your overall assessment of the applicant as to his or her ability to complete an educational program in Radiologic Technology:

- Strongly recommended
- Recommend with reservations*
- Recommended
- Do not recommend

*Please explain on separate sheet if necessary.

Signature _____ Date _____

Name _____

Title _____

Street Address _____

City _____ State _____ Zip _____

Please place the completed form in the envelope provided by the applicant.
Please be sure to seal the envelope and sign across the seal before returning it to the applicant.
Thank you for assisting us with our self-managed application process.

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