Ascension Providence Hospital
Southfield Campus

16001 West Nine Mile Road • Southfield, Michigan 48075
Phone: (248) 424-3000

SCHOOL of RADIOLOGIC TECHNOLOGY

APPLICATION FOR ADMISSION

"Qualified applicants are considered for admission to the Ascension Providence Hospital School of Radiologic Technology without regard to race, color, religion, sex, height, weight, national origin, age, sexual orientation, arrest record, marital or veteran status, or the presence of a non-job related medical condition or disability. It is the applicant's responsibility to notify us of any reasonable accommodation necessary to perform the essential duties of the position for which the applicant has applied."

IMPORTANT - PLEASE TYPE OR PRINT CLEARLY IN INK

PERSONAL DATA

Date

Social Security Number — last four only
XXX- XX-

Last Name | First | Middle

Address | City | State | Zip Code

Telephone Number (Home) | Telephone Number (Alternate) | Email Address

Person to Notify in Case of Emergency
Name

Telephone Number

Address | City | State | Zip Code

Are you age 18 or older:
Yes ☐ No ☐

Are you a U.S. citizen or otherwise authorized to work in the U.S.?
Yes ☐ No ☐

	School Name and Location	Major	Graduated	Degree / Diploma
High School			Yes ☐ No ☐	
			Yrs. Completed	
Undergraduate College/ University			Yes ☐ No ☐	
			Yrs. Completed	
Technical / Vocational			Yes ☐ No ☐	
			Yrs. Completed	

EMPLOYMENT HISTORY

Beginning with your CURRENT or most RECENT employer, list last four positions held including Military Service in date order

Name of Employer	Position Held	From To
Address	Name and Title of Supervisor	Hours Per Week
City State Zip	Reason For Leaving	Base Hourly Rate/Salary
Telephone Number	Type of Business or Institution	
Duties		

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Duties		

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED BELOW:

I hereby certify that the information given by me in this application is true and correct in all respects, and I understand that any misrepresentation, omission or falsification of information is grounds for immediate dismissal.

I understand the information on this application is subject to check and verification by Ascension Providence Hospital School of Radiologic Technology and that my previous employers may be asked for information regarding my employment with them. I hereby authorize all schools that I have attended, my former employers, my military service branch and any others having information concerning me or my past employment to release in confidence all information regarding me. I hereby release from liability each and all of those who provide such information. I understand that my acceptance into the School of Radiological Technology is dependent upon my successful completion of a physical examination to be conducted at the hospital.

I understand that this hospital operates on a twenty-four hour per day, seven days per week basis. Because of this, I understand that it may be necessary for any student to rotate shifts, and I agree to do so.

Signature of Applicant:______________________________ Date ______________

Ascension Providence Hospital
Southfield Campus

School of Radiologic Technology

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P.O. BOX 2043
Southfield, Michigan 48075
(248) 424-3000

INFORMATION RELEASE

DATE: _____

To Whom It may Concern:

I have applied to Ascension Providence Hospital's School of Radiologic Technology. In order that the School may properly evaluate my qualifications, it is my desire that it be fully advised of my employment relationship with you:

I herewith request and authorize you without qualification or limitation to release and furnish to Providence any and all information in your records, files or in your possession, concerning or relating to my present and/or past employment by you.

_____
SIGNATURE OF APPLICANT

_____
PRINTED NAME OF APPLICANT