



EMORY | SCHOOL OF MEDICINE

Radiologic Technology Certificate Program

Application for Appointment as a Student Radiographer

**** Mail all correspondence, Transcripts, etc. to:**

Emory School of Medicine

ATTN: Radiologic Technology Program

2701 N. Decatur Road • Decatur, GA 30033

Date _____

Year Applying For: 20_____

Please provide all of the needed information completely and thoroughly. Failure to submit all of the needed information will be considered an incomplete application and could possibly delay processing of application materials. **All application materials must be submitted by March 31st of the year you are applying for.**

Personal Data

Phone: _____ E-Mail Address: _____

Name _____
Last First Middle Maiden

Name preferred to be called: _____

Will you be 18 years old by the 1st Monday of September of the year you start? Yes No

Address _____
Number Street City State Zip

Person to notify in case of emergency: _____

Relationship _____ Work Phone _____ Home Phone _____

Address _____
Number Street City State Zip

Are you a United States Citizen? Yes No

Have you ever been arrested or convicted of a felony? Yes No

Legal Sex: Male Female Unknown/Prefer not to answer

Are you Hispanic or Latino? Yes No Unknown/Prefer not to answer

Regardless of your answer to the previous question, please indicate your Race/Ethnicity.

- American Indian or Alaska Native Asian Black or African American White
- Hispanic, Latino, or Spanish Native Hawaiian or other Pacific Islander
- Middle Eastern or North African Other Prefer not to answer

Education

	Institution Name	Dates Attended	Graduated?	Degree
High School				
College				
Other Schools				

Have you ever attended a Radiology Program? Yes No

Have you ever attended Emory University? Yes No

Do you identify as a 1st generation student? (First generation student is defined as a person whose parents have not received a Bachelor's degree.) Yes No

How did you hear about our program? Internet friend/ work other _____

Have you ever volunteered? Yes No

Please list any volunteer programs/ associations/ experience (ex. Churches, youth organizations, nursing home, hospital)

Have you ever been employed by Emory Healthcare? Yes No

Employment (List last employer first)

Employer	Address		Telephone
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Position Held	From	To	Reason for Leaving
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Employer	Address		Telephone
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Position Held	From	To	Reason for Leaving
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Please attach a **hand written paragraph** stating why you want to become a radiographer.

****Important:** We must have **official** high school/ college transcripts (from all schools attended) and SAT, ACT or ACCUPLACER scores. We will be interviewing in February for the class beginning September. **

Emory Decatur Hospital does not discriminate on the basis of race, color, creed, sex, religion, natural origin, or disabilities.

References

Please provide 3 (three) references below. References must be teachers, professors, supervisors, managers, or employers. *No relatives please*. Each reference **will be emailed** a reference form to complete and return.

1. _____
Name Title Relationship

Address (Number, Street, City, State, Zip) E-mail Address

2. _____
Name Title Relationship

Address (Number, Street, City, State, Zip) E-mail Address

3. _____
Name Title Relationship

Address (Number, Street, City, State, Zip) E-mail Address

The information provided in this application is true and complete to the best of my knowledge.

Signature _____ Date _____

FOR SCHOOL USE ONLY: _____

DATE APPLICATION RECV'D: _____ APPLICATION FEE RECV'D _____ Rev. 12/2024