

# OAKLAND UNIVERSITY™

SCHOOL OF HEALTH SCIENCES

## APPLICATION FOR ADMISSION TO THE RADIOLOGIC TECHNOLOGY PROGRAM

Today's Date	Start Date of Program Applying To			
Name	First	Middle	Last	Student Number
Present Address				
Number		Street		
City	State	Zip Code	Home Phone	Daytime Phone #
Permanent Address				
Number		Street		
City	State	Zip Code	Home Phone	Daytime Phone #
E-mail Address			Driver's License Number	
Other name(s), if any, you have used for work or educational records				
Are you registered, certified or licensed by any state and/or national organization?				
<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, list organizations				
Registry, Certification or License No.			Serial/Audit No.	
Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you are not a US Citizen, attach all US immigration status documents to this application.				

*Applicant – Turn page and continue*

**EMPLOYMENT BACKGROUND** LIST MOST RECENT POSITION FIRST. If presently employed, may we contact?  Yes  No

FIRST NAME	TELEPHONE	<input type="checkbox"/> Contingent <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	DUTIES AND RESPONSIBILITIES
ADDRESS	FROM	DATES TO	
STARTING POSITION			
FINAL POSITION			
SUPERVISOR			
REASON FOR LEAVING			

FIRST NAME	TELEPHONE	<input type="checkbox"/> Contingent <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	DUTIES AND RESPONSIBILITIES
ADDRESS	FROM	DATES TO	
STARTING POSITION			
FINAL POSITION			
SUPERVISOR			
REASON FOR LEAVING			

FIRST NAME	TELEPHONE	<input type="checkbox"/> Contingent <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	DUTIES AND RESPONSIBILITIES
ADDRESS	FROM	DATES TO	
STARTING POSITION			
FINAL POSITION			
SUPERVISOR			
REASON FOR LEAVING			

HEALTH CARE RELATED EXPERIENCE/VOLUNTEERISM	DATES: From	To

*Applicant – Turn page and continue*

**EDUCATIONAL BACKGROUND**

SCHOOL	NAME AND ADDRESS OF SCHOOL	COURSE OF STUDY	DATES	DID YOU GRADUATE?	LIST DIPLOMA OR DEGREE AND DATE
College # 1			From  To	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College # 2			From  To	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College # 3 If there are additional colleges/universities attended, use are below.			From  To	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Health Professional Memberships			From  To		

**ANY EXPLANATIONS TO THE ANSWERS OF THE FOLLOWING QUESTIONS SHOULD BE PROVIDED ON A SEPARATE PAGE.**

Did you serve in the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what branch	Dates of service From	Month/Year	Month/Year To
Have you ever been convicted of a crime other than a minor traffic violation (include DUI or OUI), including during military service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
The RAD program requires criminal record checks. Failure to divulge complete information will disqualify you from admission into the program. However, conviction will not necessarily disqualify an applicant from admission into the program. Are you charged with or have any pending unresolved criminal charges? (Are you charged with a crime that has not yet resulted in a plea of guilty, court trial, deferred adjudication or dropping of the charge?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain fully:			
Have you ever been suspended or discharged from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
For licensed professionals, have you been or are you currently being investigated by Federal or State governments related to your participation in Medicare, Medicaid or other Federal health programs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe the results of the investigation:			
Have you ever been subjected to a sanction as a result of a violation of an academic code, or suspended or dismissed by an educational program that you attended in order to meet any certification requirement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
For licensed professionals, have you ever had your license suspended or revoked in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
Can you perform all of the job functions of the program to which you are applying, with or without a reasonable accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No (See the Technical Performance Standards for the Program)			

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Applicant – Turn page and continue*

## APPLICATION GUIDELINES

Sign below that you have read the **Technical Performance Standards/Essential Functions** for the program, you understand them, and whether you can perform them **or** you need to speak with the program director to discuss possible accommodations.

*(Check one)*

I have read the **Technical Performance Standards/Essential Functions** for the program of Radiologic Technology, I understand them, and to the best of my knowledge, I can meet the **Technical Performance Standards/Essential Functions**.

I would like to discuss the areas of difficulty with the program director, if the program might consider modifying, so that I am able to meet the **Technical Performance Standards/Essential Functions**.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### RETURN TO:

Oakland University  
School of Health Sciences - RAD  
3110 HHB  
433 Meadow Brook Road  
Rochester, MI 48309-4452