



UnityPoint Health Des Moines

School of Radiologic Technology

Application for Admission to CT Certificate Program

Please type or print clearly and complete all information.

Personal Information

1. Date of Application _____ 2. Social Security # _____

3. Gender (optional) male female

4. Name: _____
Last First Middle Maiden

5. Current Address: _____ Phone Number _____
Number and Street

_____ City State Zip Code Country

6. E-mail Address: _____

7. Emergency Contact _____

Address _____

Telephone number (____) _____

8. Have you ever been convicted of a crime in this state or any other state? yes no
If yes, please explain _____

9. Do you have a record of founded child abuse or dependent adult abuse? yes no
If yes, please explain _____

10. Have you ever received special needs accommodations for educational purposes? yes no
(Disclosure of a disability is not a requirement for admission to the program but is required in order to receive academic and/or physical accommodations)

Radiology Education – attach additional pages if needed

| Name of School | City and State | Dates of Attendance | Did you graduate from this school? |
|----------------|----------------|---------------------|------------------------------------|
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Work Experience – attach additional pages if needed

List all radiology work experience, both full- and part-time, beginning with the most recent.

| Name of Facility | Address | Position Held | Dates of Employment |
|------------------|---------|---------------|---------------------|
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When would you like to begin the Computed Tomography Certificate Program?

____ Fall (September – December) ____ Spring (January – April) ____ Summer (May – August)

What year would you like to begin? _____

This application is to be considered for the:

____ Online Didactic Component

____ CT Clinical Internship

Certification:

It is the policy of UnityPoint Health – Des Moines School of Radiologic Technology will not condone or tolerate discrimination of patients, employees, physicians, volunteers, students, or visitors based on age, race, creed, color, gender, religion, national origin, disability, sexual orientation or gender identity.

The preceding answers are true and complete to the best of my knowledge. If I accept this appointment, I agree to abide by the rules of the Department of Radiology, Clinical Affiliates, and Iowa Health – Des Moines.

Signature of Applicant

Date

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| <p style="text-align: center;">Send application to:</p> <p style="text-align: center;"><i>Matthew J. Millard, M.S.T.D., R.T.(R)(CT)</i> <i>UnityPoint Health – Des Moines</i> <i>School of Radiologic Technology</i> <i>Radiology Department</i> <i>1200 Pleasant Street</i> <i>Des Moines, IA 50309</i></p> <p style="text-align: center;"><i>Email: matthew.millard@unitypoint.org</i></p> |
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