

**THE VALLEY HOSPITAL  
SCHOOL OF RADIOGRAPHY  
223 N. VAN DIEN AVENUE  
RIDGEWOOD, NEW JERSEY 07450**

**APPLICATION FOR ADMISSION**

Please fill out this form completely and return to the School of Radiography.

**PRINT OR TYPE ALL INFORMATION BELOW**

NAME:

Ms. \_\_\_\_\_  
Mr. \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

ADDRESS:

\_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Phone: Home: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Name and Address of Parent/Guardian/Spouse \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

**EDUCATION**

List ALL institutions attended beginning with high school. An official transcript is required from all institutions that you were enrolled in, regardless of length of time attended. If you are accepted into the program, an additional official transcript must be forwarded to FDU. No student copies, please!

Date of Attendance:

<b>From</b>	<b>To</b>	<b>Institution</b>	<b>Location</b>	<b>Credits Diploma/Degree</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**EMPLOYMENT**

List all work experience. Please include volunteer activities.

<u>From</u>	<u>To</u>	<u>Employer</u>	<u>Position</u>	<u>City and State</u>	<u>Reason for Leaving</u>

**REFERENCES**

Please provide the names and addresses of two people (not relatives) who have known you for at least five years you may include a recent teacher, counselor, employer, or clergy. Download two reference forms. Please send them to the individuals you list below. You may designate whether or not you wish to examine references. We request that you read and indicate your decision on each reference form enclosed.

1. Name \_\_\_\_\_ Position or Title \_\_\_\_\_  
Address \_\_\_\_\_
2. Name \_\_\_\_\_ Position or Title \_\_\_\_\_  
Address \_\_\_\_\_

Students may elect to receive a Certificate only from The Valley Hospital School of Radiography; however, the tuition and fees remain the same as for the Certificate / Associate Degree. Please indicate below.

\_\_\_\_\_ **Certificate / A.S. Degree in Radiography**                      \_\_\_\_\_ **Certificate (only)**

Providing false information to gain admission is cause for rejection of an applicant or dismissal of a student.

**Nondiscriminatory Practices:** The School of Radiography has recruitment and admission practices that are non-discriminatory with respect to any legally protected status such as race, color, religion, gender, age, disability, national origin and any other protected class.

If I am accepted, I agree to abide by and observe all rules and regulations of the hospital, and I understand that my acceptance is conditional based upon satisfactory completion of a physical examination, criminal background check and drug screening provided by The Valley Hospital.

**ON ONE SEPARATE PIECE OF PAPER** please type a narrative explaining your reasons for selecting radiography as a career, your reasons for selecting this program, your plans and aspirations for the future, your accomplishments which have given you the greatest satisfaction, and any additional information you feel would support your application.

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

Signature of Guardian \_\_\_\_\_ (if applicant is under 18)