



THE VALLEY HOSPITAL
SCHOOL OF RADIOGRAPHY
4 VALLEY HEALTH PLAZA
PARAMUS, NEW JERSEY 07652
(201) 447-8221
rschild@valleyhealth.com

APPLICATION FOR ADMISSION

Please fill out this form completely and mail or email as a PDF to the School of Radiography.

PRINT OR TYPE ALL INFORMATION BELOW

NAME:

Last First Middle Initial

ADDRESS:

Street City State Zip Code County

Phone: Home: (____) _____ Cell: (____) _____

Social Security # _____ E-mail Address _____

Name and Address of Emergency Contact _____
Last Name First Name Relationship

Street City State Zip Code Phone Number

Are you below the age of 18? YES _____ NO _____

Are you a citizen of the United States? YES _____ NO _____

Referred by: _____

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 The Valley Hospital. No student copies, please!

Date of Attendance:

From	To	Institution	Location	Credits Diploma/Degree
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT

List all work experience. Please include volunteer activities.

From	To	Employer	Position	City and State	Reason for Leaving
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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 _____
Email _____ Phone Number _____
2. Name _____ Position or Title _____
Address _____
Email _____ Phone Number _____

Students must have completed an Associate's Degree or higher upon admission into the program.

I certify that I have an Associate's Degree or higher and that I understand that my completion award for the program is a Certificate only from The Valley Hospital.

* Initial Here _____

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 _____