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. Revised 7/09, 03/16, 07/19

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

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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:

From	To	Institution	Location	Credits Diploma/Degree

EMPLOYMENT

List all work experience. Please include volunteer activities.

From	To	Employer	Position	City and State	Reason for Leaving

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. Enclosed are 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 is open to all qualified students without restriction as to creed, religion, national or racial origin, color, age, sex, sexual orientation, marital status or disabilities, who are able to meet the demands of the program.

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)