

ST. ELIZABETH MEDICAL CENTER  
SCHOOL OF RADIOGRAPHY  
2209 GENESEE STREET  
UTICA, NEW YORK 13501  
(315) 798-8258  
WWW.STEMC.ORG

# APPLICATION FOR ADMISSION

Name \_\_\_\_\_  
Last Name First Name Middle Initial Maiden Name

Address \_\_\_\_\_  
Number and Street  
\_\_\_\_\_  
City State Zip Code County

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_  
Area Code Number Area Code Number

Cell Phone \_\_\_\_\_  
Area Code Number

e-mail address: \_\_\_\_\_ U.S. Citizen: Yes \_\_\_ No \_\_\_

Social Security Number \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**Person to be notified in case of emergency:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Number and Street

City \_\_\_\_\_ State \_\_\_\_\_

**Pre-requisite courses completed:** yes \_\_\_\_\_ no \_\_\_\_\_

When do you wish to enter the program? \_\_\_\_\_

Have you attended our Open House? yes \_\_\_\_\_ no \_\_\_\_\_

Have you previously applied for admission to this school? yes \_\_\_\_\_ no \_\_\_\_\_

Will you require financial aid? yes \_\_\_\_\_ no \_\_\_\_\_

Have you ever been convicted of a felony or a misdemeanor? \_\_\_\_\_ If yes, explain:

-APPLICANTS ARE SELECTED IN ACCORDANCE WITH NON-DISCRIMINATORY PRACTICES-

## Education

High School \_\_\_\_\_  
Name City State

Years Attended \_\_\_\_\_ Graduated: yes \_\_\_ no \_\_\_

Diploma received: Regents \_\_\_ Local \_\_\_

**If you earned a G.E.D. (General Equivalency Diploma), indicate date earned.** \_\_\_\_\_  
(Note: copy required with application)

Please print your name exactly as it appears on your high school transcript: \_\_\_\_\_

## Post-Secondary Education: List all formal education beyond high school.

College \_\_\_\_\_  
City/State

Attended \_\_\_\_\_ to \_\_\_\_\_ Graduated yes \_\_\_ no \_\_\_

Major \_\_\_\_\_

College \_\_\_\_\_  
City/State

Attended \_\_\_\_\_ to \_\_\_\_\_ Graduated yes \_\_\_ no \_\_\_

Major \_\_\_\_\_

## Employment

Name \_\_\_\_\_ Position Held \_\_\_\_\_

Address \_\_\_\_\_ Employment Dates \_\_\_\_\_ to \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

Name \_\_\_\_\_ Position Held \_\_\_\_\_

Address \_\_\_\_\_ Employment Dates \_\_\_\_\_ to \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

**Professional References (please have your references use our forms)**

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

**Application Check List**

***Please submit this application with the following items completed or included:***

\_\_\_\_\_ Non-refundable Application Fee payable to St. Elizabeth Medical Center School of Radiography of \$40

\_\_\_\_\_ **Official** High School/GED and All College Transcripts Requested

\_\_\_\_\_ All items on Application Answered

\_\_\_\_\_ Admission Addendum

\_\_\_\_\_ Three Professional References Using Our Official Forms.

***Failure to comply will delay the processing of your application.***

**I certify that I have not knowingly withheld information or given false information on this application. I understand that withholding information or giving false information may make me ineligible for admission or to continue my enrollment at St. Elizabeth School of Radiography.**

**I consent to any and all admission-related examinations, including but not limited to health and drug screening tests and background investigation checks as required by St. Elizabeth School of Radiography. I agree that admission to St. Elizabeth School of Radiography may be made conditional upon successful completion of such examinations and tests.**

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

**APPLICATION FOR ADMISSION  
ADDENDUM**

Dear Applicant:

The following is requested for State Reporting and Financial Aid use only. This information will be held in strict confidence and will not be used in anyway for determining eligibility criteria for admission to St. Elizabeth College of Nursing or St. Elizabeth School of Radiography. The attached Consumer Disclosure Form needs to be signed and all forms returned with your application.

Applicant Name: \_\_\_\_\_

Ethnic Identity (please check one)

- |  |  |
|--|--|
| <input type="checkbox"/> White                                     | <input type="checkbox"/> Asian                     |
| <input type="checkbox"/> Hispanic/Latino                           | <input type="checkbox"/> Non-Resident Alien        |
| <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> American Indian or Alaskan Native         | <input type="checkbox"/> Two or more races         |
| <input type="checkbox"/> Race and ethnicity unknown                |  |

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Social Security Number: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_

If married please give spouse's name: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

Will you need Financial Aid? Yes  No

Do you currently hold an Associates Degree? Yes  No

Do you currently hold a Bachelors Degree? Yes  No

Are you eligible for Veterans Assistance? Yes  No

Does your employer offer tuition reimbursement? Yes  No

Will you be in need of Dorm Facilities? Yes  No

Voluntary Information

Are you in need of disability services? Yes  No

Note: For questions or information on services to students with disabilities, our Disabilities Coordinator can be reached at (315) 798-8126