

**ARKANSAS STATE UNIVERSITY  
COLLEGE OF NURSING AND  
HEALTH PROFESSIONS**



**DEPARTMENT OF MEDICAL IMAGING AND RADIATION SCIENCES**

**APPLICATION FOR ADMISSION**

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

Last

First

Middle

Social Security #: \_\_\_\_\_

Phone Numbers: ( ) \_\_\_\_\_ home ( ) \_\_\_\_\_ cell

Present Address: \_\_\_\_\_

City

State

Zip

Permanent Address: \_\_\_\_\_

(If different)

City

State

Zip

AART #: \_\_\_\_\_

Radiography School	Certificate or Degree	Date of Graduation

List your work experiences in health care institutions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Notification of admission decision should be sent to: \_\_\_\_\_ present address \_\_\_\_\_ or permanent address. If applicant does not indicate choice, notification will be sent to the first address given above.

If your name, address or phone number changes during the application process, please notify the Department of Medical Imaging and Radiation Sciences of these changes.

Students applying to the Department of Medical Imaging and Radiation Sciences must also apply for admission to Arkansas State University. Please see the ASU website for admission information at <http://admissions.astate.edu/>. Or contact the Office of Admissions and Records, P. O. Box 1630, State University (Jonesboro), AR 72467 or phone (870) 972-3024.

### **APPLICATION PACKET**

Only completed packets will be accepted and must be returned to the Program Director. With this form, applicants are required to submit the following documents:

1. College/Hospital Transcript(s) of all work attempted
2. Copy of ARRT card

Students accepted into the Department of Medical Imaging and Radiation Sciences will be expected to travel to assigned clinical affiliates and will be responsible for transportation and all expenses related to travel.

I hereby affirm that all information supplied on this application is complete and accurate. It is my understanding that I will not be considered for admission to this program until I have submitted all credentials specified by the set date.

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Date Signature

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For applicants who are proficient in the Spanish language:  
Actualmente en la región que sirve ASU, se necesitan profesionales de la salud que hablen español. Por favor, indique aquí si usted tiene esta habilidad. Se da crédito adicional a los candidatos que puedan demostrar esta competencia. La facultad de idiomas extranjeros de ASU administra la prueba de habilidad en español. Por favor, póngase en contacto con el programa de Ciencia Radiológica para arreglar una cita para tomar el examen.

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**Please submit application packet to:**

ASU Department of Medical Imaging and Radiation Sciences  
Program Director  
P.O. Box 910  
State University (Jonesboro), AR 72467-0910

**Arkansas State University  
College of Nursing & Health Professions  
Criminal Background**

Student name: \_\_\_\_\_

I understand that criminal background checks will occur as part of my professional education at ASU. Evidence of a previous charge or conviction of a felony/misdemeanor on my record may affect my progress in this program. While the faculty cannot realistically determine whether this will have any future impact on my ability to work in my profession, I do understand that the following issues could arise during my time as a student or as a graduate of the program.

1. Certain rotation sites could deny me access for rotation.
2. Hospitals or other health care institutions could refuse to allow me access for a clinical experience.
3. The above two issues could make it impossible for me to complete the clinical portion of my education and therefore not graduate.
4. Upon graduation, a state licensing agency could refuse to grant me a license.
5. As a licensed professional, certain health care institutions could refuse to grant me privileges.
6. There could be other, unforeseen, impacts of this incident on my ability to practice as a professional.

Student signature: \_\_\_\_\_

Date: \_\_\_\_\_