ARKANSAS STATE UNIVERSITY
COLLEGE OF NURSING AND
HEALTH PROFESSIONS

RADIATION THERAPY PROGRAM

APPLICATION FOR ADMISSION

(Returning or Transfer Students)

Deadline for Applications:

Application material must be received by April 1st for admittance into the program. Applications are reviewed after the application deadline and are *not* reviewed on a first served basis. Faxed applications will not be accepted.

Name: _____
Last First Middle

E-mail: _____

Phone Numbers: ( ) _____home ( ) _____ cell

Present Address: _____

_____
City State Zip

Permanent Address: _____

(If different) _____
City State Zip

List your work experiences in health care institutions:

_____

_____

_____

_____

Have you ever participated in a MASH (Medical Applications of Science in Health) program or a CHAMPS (Community Health Applied for Medical Public Service) program? If yes, when and where? (For statistical purposes only)

_____

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 Radiologic Sciences Department of these changes. (870) 972-3073

Students applying to the Radiation Therapy program must also apply for admission to Arkansas State University. Please see the A-State 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. 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. Modality/clinic evaluation form
3. Radiation Therapy application form
4. Essay describing yourself and why you want to enter the Radiation Therapy program

Students accepted into the Radiation Therapy program 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.

_____ _____

Date Signature

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 Radiologica para arreglar una cita para tomar el examen.

Please submit application packet to:

A-State Radiation Therapy Program
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 may 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: _____