OSF Saint Francis Medical Center
School of Radiography

530 N.E. Glen Oak Avenue
Peoria, Illinois 61637

APPLICATION FORM

A. Personal Data

Name _____ _____
Last First M.I. Previous Name (if applicable)

Address _____ **Telephone** _____
Street Address

_____ **Date of Birth**_____
City State Zip

Email _____

- Will you be at least 18 years of age by the program start date of the year for which you are applying?
  ◯ **YES** ◯ **NO**

Person to contact in case of emergency _____
Name

_____
Address City/State/Zip Telephone

B. Education

	Name & Location of School	Dates Attended/Degree
High School		
College		
College		
Other		

Please list below the **course(s) you are currently enrolled in or plan to take** in upcoming quarters/semesters:

College Name/Location	Quarter or Semester/Year	Course name/number
e.g. Illinois Central College, E. Peoria IL	Fall, 201X	Anatomy & Physiology w/ Lab / BIOL 140

C. Employment

Please list last employer first. Account for every year.

Name/Address of employers	Type of Business	Employment dates	Position Held	Reason for leaving

D. Non-cognitive Performance Standards

I have read and understand the "Non-cognitive Performance Standards" (contained in program information) for the radiography program and profession.
I am able to meet the Communications/Interaction, Visual, Hearing and Motor Function Standards with or without reasonable accommodations.

_____

Signature Date

Are you aware of any reason you would NOT be able to perform these tasks, with or without reasonable accommodations? ◯ YES ◯ NO
(If unable to perform task(s), please attach an explanation on a separate sheet.)

E. Character References

List names/occupations of *three* character references you wish to use, two from recent employers and/or teachers and one personal. *(Give reference forms to these persons.)*

1. _____

2. _____

3. _____

F. Signature

I, _____, certify that the information on this application is true and accurate to the best of my knowledge.

_____

Applicant Signature **Date**