

**SwedishAmerican Health System
School of Radiation Therapy
Admissions Application**

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Please indicate the option that you are applying for:

Certificate/Radiography Option _____

Certificate/Baccalaureate Option _____

Please indicate the school term year that you are applying for: Fall _____

Would you like a current University of St. Francis Catalogue? _____

I. Personal Information

Name _____
Last First Middle

Address _____
Number and street City State Zip

Phone (____) _____

II. Education

High School _____ From _____ to _____

Address _____

Technical/ _____ From _____ to _____
Professional School

Degree _____

Address _____

College/ _____ From _____ to _____
University

Degree _____

Address _____

Additional _____ From _____ to _____
Education

Degree _____

Address _____

Please send *official* high school, technical school, and college transcripts to the School of Radiation Therapy.

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III. **Academic References** (Please list persons not related to you, i.e. professors, program directors, instructors)

1. Name _____
Address _____
Phone _____ How long known _____
Relationship _____

2. Name _____
Address _____
Phone _____ How long known _____
Relationship _____

IV. **Professional References** (Please list at least 2 persons not related to you, i.e. previous managers, supervisors, clinical instructors)

1. Name _____
Address _____
Phone _____ How long known _____
Relationship _____

2. Name _____
Address _____
Phone _____ How long known _____
Relationship _____

3. Name _____
Address _____
Phone _____ How long known _____
Relationship _____

V. Current/Formal Employment

1. Name _____ From _____ to _____
Address _____
Phone _____

2. Name _____ From _____ to _____
Address _____
Phone _____

3. Name _____ From _____ to _____
Address _____
Phone _____

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- VI. Please describe (type or write) in the space below, why you have chosen radiation therapy as a career. Briefly explain how you became acquainted with this field of study.

Applicant Statement:

I understand that any false statements made as part of this application will be considered as sufficient cause for application disqualification. I also grant permission to the authorities of this school to investigate any references, and I release the hospital from any and all liability resulting from such investigation. I consent to any and all medical examinations required by the hospital to be considered for program admission. Upon completion of the program, I authorize the release of any academic performance information as a student in the program to potential employers.

Applicant signature _____ Date _____

******Three recent letters of recommendation must be submitted at the time of application. 2 of the 3 required recommendation letters must come from academic acquaintances (professors, clinical instructors, program directors). Letters must be sealed and sent directly to the School of Radiation Therapy.***

Application Deadline is January 31st yearly.

Send completed application to:
SwedishAmerican Hospital
School of Radiation Therapy, Program Director
1401 East State Street
Rockford, Illinois 61104

Admission to the SwedishAmerican School of Radiation Therapy is granted without regard to race, color, religion, gender, age, disability or national origin.