SWEDISHAMERICAN
A DIVISION OF UW HEALTH

SwedishAmerican Hospital
School of Radiography
APPLICATION FOR ADMISSION

PERSONAL & CONTACT INFORMATION

First name:	Last name:	(Maiden):
Address:		
City:	State:	ZIP:
Phone 1	Type: ☐Cell ☐Home ☐Work	
Phone 2	Type: ☐Cell ☐Home ☐Work	
Email:		
Are you 18 years of age or older? ☐Yes ☐No		
Have you been convicted of a felony or misdemeanor? If yes, state the nature of the crime, when, where and disposition of offense.		
I am applying for admission to the: ☐Certificate Track ☐Baccalaureate Track		
Anticipated Start Date (Month and Year)		

EDUCATION

School 1:		
Address:		
City:	State:	ZIP:
Dates Attended:	Degree Earned:	

School 2:		
Address:		
City:	State:	ZIP:
Dates Attended:	Degree Earned:	

School 3:		
Address:		
City:	State:	ZIP:
Dates Attended:	Degree Earned:	

(If there are more than 3 schools, please email with your application on a separate sheet of paper)

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EDUCATION *continued*

Please describe your volunteer or extracurricular activities, and any awards or honors you have received.

EMPLOYMENT

Please list your most recent employer first. This section may be left blank if you have no employment history.

Employer 1:		
Address:		
City:	State:	ZIP:
Phone:	Position Held:	
Dates Employed:	Reason for Leaving:	

Employer 2:		
Address:		
City:	State:	ZIP:
Phone:	Position Held:	
Dates Employed:	Reason for Leaving:	

Employer 3:		
Address:		
City:	State:	ZIP:
Phone:	Position Held:	
Dates Employed:	Reason for Leaving:	

(If you have more than 3 employers, please list on a separate piece of paper and email with your application).

Do you have prior experience in another area of healthcare? If yes, please explain.

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Why have you chosen a career in the radiologic Sciences? What are your short-term and long-range career goals.

EMPLOYMENT AND/OR ACADEMIC REFERENCES

For an employment reference, the person listed must be a supervisor or co-worker.

For academic references, please list instructor or advisors. Forms will be sent to the references you have indicated upon receipt of your application. It is not necessary for your references to send a letter. They will have the opportunity to write additional comments on the form we email to them. Personal references are not accepted (family and friends).

Reference 1: Name		Email:
Address:		
City:	State:	ZIP:
Phone:	Relationship to Applicant:	

Reference 2: Name		Email:
Address:		
City:	State:	ZIP:
Phone:	Relationship to Applicant:	

Reference 3: Name		Email:
Address:		
City:	State:	ZIP:
Phone:	Relationship to Applicant:	

APPLICANT CERTIFICATION

By signing this application for, I certify that the statements made on the application are true and complete. I understand that any false statements made on this application constitute sufficient cause for rejection of the application for admission and/or dismissal from the program following enrollment. I authorize investigation of all statements made and all references listed on this application, and release SwedishAmerican Hospital and the School of Radiography from any and all liability from this investigation.

*****Failure to fill out application completely will void your application. *****

Applicant Signature:

Please save this form and then email completed application to csalsbury@swedishamerican.org.