

**JONES COUNTY JUNIOR COLLEGE
RADIOGRAPHER PROGRAM APPLICATION
900 South Court Street, Ellisville, MS 39437
(601)-477-4159**

Name _____
(Last) (First) (Middle)

Mailing Address _____
(Street) (City) (State) (Zip code)

Social Security Number _____ Telephone _____

Student I.D. Number _____ Email address _____

Are you at least 18 years of age? ___yes ___no Who referred you to us?
Do you have personal obligations that would cause you to miss school? _____yes _____no
If accepted do you plan to work or attend any other school?_____yes _____no If yes, please indicate
nature and weekly hours.
Are you physically and mentally able to perform the duties for which you have applied? ___yes ___no
If not, could you perform these functions if a reasonable accommodation were made? ___yes ___no
Please explain. _____
Have you ever been convicted of a crime? _____yes _____no (If yes explain)

* Conviction of a crime is not an automatic bar to enrollment. All circumstances will be considered.

In case of emergency notify:

Name Relationship Address Telephone(Home/Work)

Educational History

School name Address Yrs. Attended Major

Have you ever been enrolled or applied for admission to this or any other Radiography Program?
___yes ___no If yes, School name _____ Date _____

If you were enrolled, why was your education interrupted? _____

WORK HISTORY: Please list your most recent employer first.

Employer (Name, address, telephone)	Position Held	Salary	Dates From-Thru	Reason for leaving
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May we contact the employers listed above? _____yes _____no

MILITARY EXPERIENCE: Branch _____ Rank Achieved _____

Special Training/Schools _____

Date entered _____ Date Discharged _____

REFERENCES: (3) List references other than relatives. **Please include address and telephone.**

Equal opportunity is given to all applicants regardless of race, creed, national origin, sex, age, or individuals with disabilities.

I certify that the answers given me to the foregoing questions and statements are true and complete to the best of my knowledge and that I have withheld nothing that would, if disclosed, affect this application unfavorably. I authorize the companies, schools, or persons named herein to give information regarding my employment, character, and qualifications, together with any information they may have regarding me, whether or not it is in their records. I hereby release said companies, schools, or persons from all liability for any damage for issuing this information. I understand that any misleading or incorrect statements may render this application void, and if enrolled, cause my immediate dismissal.

My health information will be recorded on the medical report form supplied by the Radiographer Program and returned to the Program Director prior to March 1st. If selected for entry into the program, I agree to submit myself to a physical examination, by my physician, at my expense.

If accepted into the program, I authorize the school to release to perspective employers any information regarding my enrollment with the school or the information set forth in this application or gained by the school from any other companies, schools, or persons named in this application to give information regarding my employment, character, qualifications, and information they may have, regarding me, whether or not it is in their records. I hereby release the school from all liability for any damage for issuing this information.

APPLICANT SIGNATURE

DATE

CONFIDENTIAL REFERENCE FORM

PART I (To be completed by the applicant and given to a professional person or past employer for completion)

Name of Applicant _____

Mailing Address _____ Telephone _____

I hereby waive my right of access to this confidential recommendation as provided in the Educational Rights and Privacy Act of 1974. **(Optional)**

Signature _____ Date _____

● *****

PART II (To the person serving as a reference)

Please note the waiver statement above. Once you have completed the enclosed form please return it to:

**Jones County Junior College
Radiographer Program
900 South Court Street
Ellisville, MS 39437**

Please mark the most appropriate column beside each trait listed below:

APPLICANTS TRAIT	RATING:				
	EXCELLENT	GOOD	FAIR	POOR	NOT KNOWN
Dependability					
Initiative					
School/Work Performance					
Motivation toward goals					
Maturity					
Emotional Stability					
Ability to work with others					
Judgment					
Ability to follow instructions					
Ability to accept criticism					
Concern for others					
Self Confidence					
Analytical Ability (Problem Solving)					
Oral Expression					
Written Expression					

How long have you known this applicant?

In what relationship? _____

Describe major strengths of the applicant.

Describe major weaknesses of the applicant.

Please include any additional information you feel would be beneficial to the Interview Committee in its consideration of this applicant.

PLEASE INDICATE YOUR RECOMMENDATION OF THIS APPLICANT FOR ACCEPTANCE INTO THIS HEALTH RELATED EDUCATIONAL PROGRAM.

HIGHLY RECOMMEND	RECOMMEND	RECOMMEND WITH RESERVATION	DO NOT RECOMMEND	NO OPINION

Signature _____ Date _____

Name (Please print or type) _____ Position/Title

Institution/Company

Address and telephone

THIS RECOMMENDATION MUST BE RETURNED NO LATER THAN MARCH 1st

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Mailing Address _____ Telephone _____

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Institution/Company

Address and telephone

THIS RECOMMENDATION MUST BE RETURNED NO LATER THAN MARCH 1st

**Jones County Junior College
Health and Human Service Programs
Ellisville, Mississippi 39437**

Report of Medical Examination

Name _____

Address _____

Social Security Number _____ Telephone _____

I hereby authorize the information contained herein to be released to Jones County Junior College for such purpose as they may desire, without prejudice to them. This information is to be kept in their confidential files. I understand that any false information I give for this record may result in the immediate termination of my enrollment in the program.

Applicant Signature _____ **Date** _____

Medical History

Please indicate if you have ever experienced any of the following. If you answer yes in any space, please explain in the space provided.

	Yes	No		Yes	No
Epilepsy			Stomach Trouble		
Fainting			Back Trouble		
Heart Trouble			Operations		
Cancer			Asthma		
Accidents			Kidney Trouble		
Compensation Injury			Diabetes		
Mental Trouble			Armed Forces		
Rheumatism			Menstrual Trouble		
Nervousness			Date of last period		
High Blood Pressure			Current Medications		
Other (explain)			Other (explain)		

Please include an explanation for any yes answer.

You must return this form with your application. Complete ONLY the front sheet. If you are selected for entry into the program for which you have applied, a satisfactory physical examination, by the physician of your choice, will be required.

1. Head _____ Neck _____ Nose _____ Teeth _____ Tonsils _____ Thyroid _____	8. Eyes: _____ Near vision: w/o glasses _____ with glasses _____ Distant Vision: w/o glasses _____ with glasses _____ Color Perception _____ Red/Green _____ Yellow/Green
2. Hearing R _____ L _____	9. Heart _____
3. Thorax _____ Lungs _____	10. Abdomen
4. Hernia R _____ L _____	11. Spine
5. Upper Extremities Joints R _____ L _____ Arms R _____ L _____ Hands R _____ L _____	12. Lower extremities Joints R _____ L _____ Legs R _____ L _____ Feet R _____ L _____ Varicose Veins R _____ L _____
6. Skin	13. Genitalia
7. Emotional Stability	14. History of Mental Illness
TB Skin Test	Varicella Titer
HBV Vaccine <i>(optional except Emergency Technologist Students)</i>	HIV Test <i>(optional for all students)</i>
Current prescription Medications	Purpose of Medications

Please indicate any abnormal item by number(s):

PHYSICIAN RECOMMENDATION

- Accept
 Acceptable with abnormalities present
 Acceptable only if abnormalities corrected
 Unacceptable

Comments (If Applicable):

Physician Signature _____ **Date** _____

APPLICANT CHECKLIST

This checklist is included to provide you a means of insuring all application materials have been submitted. Please make sure all requested information on the application and supporting forms is complete and legible. Please make sure you include full addresses, telephone numbers, and other such information where requested.

_____	Application
_____	Applicant information form
_____	(1) Personal Reference Form
_____	(1) Employer Reference Form (if applicable).
_____	ACT scores
_____	College Transcript(s)
_____	Report of Medical Examination (Completed front page only)

PLEASE NOTE:

- **ALL FORMS AND SUPPORTING INFORMATION MUST BE SUBMITTED TO THE RADIOGRAPHY PROGRAM OFFICE AS A COMPLETE PACKET NO LATER THAN MARCH 1ST**
- **INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT**
- ***ONLY COMPLETE APPLICATIONS SUBMITTED ON OR BEFORE MARCH 1st WILL BE CONSIDERED***

This form is for YOUR RECORD. It is recommended that you record the date as each requirement is completed.