

JONES COUNTY JUNIOR COLLEGE
Diagnostic Medical Sonography
ELLISVILLE, MS 39437
(601)-477-4289

Name _____
 (Last) (First) (Middle)

Social Security Number _____ - _____ - _____ Telephone _____

Email address _____

Resident Address

 (Street) (City) (State) (Zip code)

Are you at least 18 years of age? ___YES ___NO Who referred you to us? _____

How far do you live from the college? _____

How will you get to and from school? _____

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.

In case of emergency notify: _____

	Name	Relationship
Address	Telephone Work	Home

EDUCATION

School name	Address	Yrs. Attended	Major

Have you ever applied for admission to any other School of Diagnostic Medical Sonography? ___ YES ___ NO

** If yes, School name _____ Date _____

Have you ever been enrolled in a school of Diagnostic Medical Sonography? ___ YES ___ NO **If yes, please

indicate school name. _____ Date: _____

Why was your education interrupted? _____

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.**

WORK HISTORY: Please list your most recent employer first.

Employer Name and Address	Position	Salary	Dates	Reason for leaving

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 Sonography Program and returned to the Program Director prior to beginning class. 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 previous instructor and a past employer for completion. The third form may be given to someone from another professional field.

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 wavier statement above. Once you have completed the enclosed form please return it to: Jones County Junior College, Diagnostic Medical Sonography Program, 900 South Court Street, Ellisville, MS 39437.

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

	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	_____	_____	_____	_____	_____
Oral Expression	_____	_____	_____	_____	_____
Written Expression	_____	_____	_____	_____	_____

** Sonography is a very "tech-dependent" field so honesty is vital. Sonographers are the "eyes of the doctor". You may respond with "I prefer not to answer" if you are uncomfortable answering honestly.*

How long have you known this applicant and in what capacity?

Describe major strengths of the applicant.

1. _____

2. _____

3. _____

Describe major weaknesses of the applicant.

1. _____

2. _____

Please include any additional information you feel would be beneficial to the Admissions 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

PREFER NOT TO
RECOMMEND

Signature _____ Date _____

Name (Please print or type)

Position/Title

Institution/Company

Address and telephone

May we contact you with questions? _____ yes _____ no

Additional Comments: _____

PLEASE RETURN THIS FORM NO LATER THAN April 30th.

**Jones County Junior College
Health and Human Service Programs
Attention Diagnostic Medical Sonography
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.

****This side of form is to be completed by your physician.**

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 R _____ L _____ Joints Arms Hands	12. Lower extremities R _____ L _____ Joints Legs Feet Varicose Veins
6. Skin	13. Genitalia (if there is a potential problem with program completion)
7. Emotional Stability	14. History of Mental Illness
TB Skin Test	Varicella Titer
HBV Vaccine __ (<i>optional for DMS 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

A=Acceptable

B=Acceptable with abnormalities present

C=Acceptable only if abnormalities corrected

D=Unacceptable

Comments (If Applicable): _____

Physician Signature: _____ **Date:** _____

Checklist for Turning In Materials

On or before **April 30th** make sure that you have:

_____ **Submit the completed application form.**

_____ **Assure that the following items have been received:**

A.C.T. scores

College transcripts, if applicable (**J.C.J.C. Transcripts will be obtained by the program.**)

Midterm grades, if applicable (**J.C.J.C. Transcripts will be obtained by the program.**)

_____ Reference forms (3)

_____ **Two sets of A.C.T. scores and sealed official transcripts** from the registrar of the previous institution in a **sealed** envelope: **One** must be **given to the DMS Program Director**. The other official transcript must be mailed to the JCJC Registrar's office for admission to the JCJC.

_____ **Faculty will request Jones County Junior College transcripts directly from the Registrar.**

_____ **Reference letters should be returned by the person completing the reference form not by the applicant.**

_____ **Submit documentation of:** (1) A.R.R.T. Registry, in good standing, (2) Registry-eligible status with the A.R.R.T or (3) transcripts verifying completion of two year allied health program or Bachelor's degree from an accredited facility.

Applicants who submit all the required materials and meet minimum requirements will be invited to an interview with the Program Director and/or DMS Admissions Committee.

Qualified applicants will be notified of the date, time and location of the interview by mail.

FAILURE TO SUBMIT ALL INFORMATION OR COMPLETE ALL REQUIREMENTS ON OR BEFORE THE DATES INDICATED WILL VOID THE APPLICATION.