COLLEGE OF SOUTHERN IDAHO

DEPT. OF HEALTH SERVICES AND HUMAN SERVICES
315 Falls Avenue • P.O. Box 1238 • Twin Falls, Idaho 83303
(208) 733-9554, Ext. 6701 • Fax: (208) 736-4743
(800) 680-0274 (in Idaho and Nevada)
TDD (208) 734-9929 Web Site: http://www.csi.edu

APPLICATION FOR ADMISSION
TO THE RADIOLOGIC TECHNOLOGY PROGRAM

Name _____
FIRST MIDDLE LAST FORMER NAME

Home Address _____
STREET ADDRESS CITY STATE COUNTY ZIP CODE

Permanent Address *(if different from above)* _____

Social Security Number _____ Home Phone: ( ) _____
AREA CODE

Business Phone: ( ) _____ ☐ Male ☐ Female
AREA CODE

EDUCATION

Official Transcript(s) MUST BE RECEIVED by the Office of Admissions and Records and a copy must be received by the Chairman of Health Science and Human Services

NAME OF SCHOOL	LOCATION OF SCHOOL	FROM MONTH / YEAR	TO MONTH / YEAR	DID YOU RECEIVE DIPLOMA? DEGREE? CERTIFICATE?	WHAT WAS YOUR MAJOR / MINOR?
HIGH SCHOOL OR GED					N/A
COLLEGE OR UNIVERSITY					

	TYPE	ISSUED BY WHICH STATE OR AGENCY	LICENSE NO.	DATE
Professional Licenses				
or Certification				

FOLLOW UP INFORMATION

It is important that we follow up our students to be sure they obtain appropriate employment. Please provide information about two people who will always know where to locate you.

	NAME	MAILING ADDRESS	TELEPHONE NO.
1			
2			

HEALTH RELATED WORK EXPERIENCE AND/OR VOLUNTEER EXPERIENCE

Employer _____ Phone No. _____ Ext. _____

Address _____
STREET ADDRESS CITY STATE ZIP CODE

Dates Employed: From _____ To _____ Nature of Your Job Duties _____

Reason for Leaving _____ ☐ Full ☐ Part-time

Employer _____ Phone No. _____ Ext. _____

Address _____
STREET ADDRESS CITY STATE ZIP CODE

Dates Employed: From _____ To _____ Nature of Your Job Duties _____

Reason for Leaving _____ ☐ Full ☐ Part-time

REFERENCES

Two references are required. *Do not list personal friends or relatives.* Please provide a complete mailing address and telephone number on both names listed below.

1	EMPLOYER	ADDRESS	PHONE
	OCCUPATION		EXT.
2	NAME	ADDRESS	PHONE
	OCCUPATION		EXT.

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

PLEASE READ AND SIGN BELOW

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misinterpretation or falsification of information is cause for denial of admission or expulsion from the College. I understand that illegal use, possession, and/or misuse of drugs are reasons for immediate dismissal from any of the programs in the Health Sciences and Human Services Department. I understand that a felony conviction may prevent me from obtaining a radiologic technology degree.

SIGNATURE OF APPLICANT _____ DATE _____