

**Nuclear Medicine Program
Application**

Directives

- 1.) Upon completion of this application, please e-mail it directly to Program Director David Kelkis, CNMT, NMTCB(CT), RT(N)(CT)(ARRT) at dkelkis1@jh.edu
- 2.) Mail an application fee of **\$40.00 in the form of check or money order made out to The Johns Hopkins Hospital at the address listed in the top-left corner of this document. Cash payment will not be accepted.** *Applications will not be reviewed until the application fee has been received.*
- 3.) **Digitally release all post high school transcripts** directly to the Johns Hopkins Schools of Medical Imaging via e-mail to Program Director David Kelkis at dkelkis1@jh.edu
- 4.) Completed Recommendation Forms must be **e-mailed directly from the referrer** to Program Director David Kelkis at dkelkis1@jh.edu

Personal Data

Name: _____
Last First Middle

Preferred Name: _____ **Pronouns:** _____

Current Address:

Street Address

City State Zip Code

Permanent Address:

Street Address

City

State

Zip Code

E-Mail Address: _____ **Phone Number:** _____

Will you be 18 years of age on or prior to the start of the program? ☐ YES ☐ NO

Are you a United States citizen? ☐ YES ☐ NO

If NO, do you have a Permanent Resident Card? ☐ YES ☐ NO

Education Data

To be eligible to apply to this program, applicants must be either a currently enrolled university affiliate student or have earned, at minimum, an associate degree by the program start date.

Are you a currently enrolled university affiliate student? ☐ YES ☐ NO

If YES, please indicate the university affiliate in which you are currently enrolled:

☐ Bloomsburg University

☐ Immaculata University

☐ Millersville University

☐ Notre Dame of Maryland University

☐ York College of Pennsylvania

College/university of earned degree: _____

Date degree received/expected (month/year): _____

With the most recent first, please list any colleges/universities/professional schools attended in the table below:

College/University/Professional School	Location	Years Attended (From / To)	Graduate	Degree/Diploma/Certification Awarded
		/	☐ YES ☐ NO	
		/	☐ YES ☐ NO	
		/	☐ YES ☐ NO	
		/	☐ YES ☐ NO	
		/	☐ YES ☐ NO	

If any academic transcripts are under a different name, please provide that name here:

List any held professional certifications and/or licenses in the table below (e.g. CNA, CNMT, EMT, RN, RT, etc.)

Professional Certification/License	Number	Effective Date

Place a checkmark below to indicate prerequisite courses completed and indicate the semester enrolled/planned to enroll. All prerequisite coursework must be completed prior to the start of the program.

Course	Complete		Enrolled Semester
Human Anatomy & Physiology I (4 credits, with laboratory)	☐	☐	
Human Anatomy & Physiology II (4 credits, with laboratory)	☐	☐	
College Physics (4 credits, with laboratory)	☐	☐	
College Chemistry (4 credits, with laboratory)	☐	☐	
College Algebra or Higher Mathematics	☐	☐	
Medical Terminology (for credit, college level)	☐	☐	
Interpersonal Communication or Speech	☐	☐	
English Composition	☐	☐	

Employment Data

With the most recent first, list all employers for the last five years in the table below.

Employer	Employer Address	Position Title	Time Employed (From / To)
			/
			/
			/
			/
			/

Describe any volunteer work completed:

Reference Forms

All applicants are required to submit **two Recommendation Forms**. **All Recommendation Forms must be sent directly from the referrer via e-mail** to Program Director David Kelkis at dkelkis1@jh.edu.

Only the provided Recommendation Form will be accepted.

The Johns Hopkins Schools of Medical Imaging requires that applicants provide Recommendation Forms from one professor of a prerequisite science course (Anatomy & Physiology is preferred), and one Reference Form from a current employer. *If unable to provide Recommendation Forms as required, e-mail Program Director David Kelkis at dkelkis1@jh.edu*

Attestation

If applicable, indicate all other programs at the Johns Hopkins Schools of Medical Imaging that you are applying to below:

☐

Radiography Program

☐

Diagnostic Medical Sonography Program

How did you hear about the Johns Hopkins Schools of Medical Imaging?

I hereby certify that the statements set forth in the above application are true and complete to the best of my knowledge. I understand that, if accepted, falsified statements on this application will be considered sufficient cause for Dismissal from the program.

I also understand that admission into the program implies my agreement to adhere to all hospital and program policies and regulations.

If selected for the program, I agree to submit to a background check and pre-employment physical, to include a drug screening, administered by the occupational health department of The Johns Hopkins Hospital prior to beginning classes.

Signature: _____ **Date:** _____

The Johns Hopkins Schools of Medical Imaging does not discriminate on the basis of: race, color, ancestry or national origin, immigration status, ethnicity, age, disability, religion, sex, gender, pregnancy, military status, veteran status, marital status, sexual orientation, gender identity or expression, genetic information, and other legally protected characteristics.

August 2024