



**JOHNS HOPKINS HOSPITAL SCHOOL OF CARDIAC SONOGRAPHY
ADULT ECHOCARDIOGRAPHY LABORATORY
1800 ORLEANS ST. SHEIKH ZAYED TOWER, ROOM 4052
BALTIMORE, MARYLAND 21287**

APPLICATION FORM

FOLLOW DIRECTIONS CAREFULLY

1. TYPE OR PRINT LEGIBLY ALL INFORMATION.
2. ATTACH CHECK OR MONEY ORDER FOR 40.00 PAYABLE TO JOHNS HOPKINS HOSPITAL.
3. FAILURE TO ANSWER ANY REQUIRED SECTION OR FAILURE TO SUBMIT AN APPLICATION FEE WILL BE GROUNDS FOR DISQUALIFICATION OF THE APPLICANT.
4. REQUEST ALL PREVIOUS SCHOOL / COLLEGE TRANSCRIPTS TO BE SENT TO THE ADDRESS ABOVE.

A. PERSONAL DATA

1. NAME: _____
 LAST FIRST MIDDLE

ADDRESS: _____
 ADDRESS STREET

 CITY STATE ZIP CODE

2. SOCIAL SECURITY NUMBER: ____-____-____

3. CONTACT: HOME: () _____ WORK: () _____
 CELL PHONE () _____

4. E-MAIL: _____

5. DATE OF BIRTH: _____

B. EDUCATION

LIST COLLEGES OR SCHOOLS ATTENDED WITH MOST RECENT FIRST: IF TRANSCRIPTS ARE UNDER ANOTHER NAME PLEASE INDICATE _____.

COLLEGE/SCHOOL & LOCATION	YEARS ATTENDED		GRADUATE		DEGREE AND/OR DIPLOMA
	FROM	TO	Y	N	

LIST BELOW ALL PROFESSIONAL CERTIFICATIONS AND/OR LICENSES (E.G., RN, R.T., R.D.M.S., ETC.) WITH EFFECTIVE DATES:

LICENSE/CERTIFICATION	NUMBER	EFFECTIVE DATE

C. EMPLOYMENT

PLEASE LIST ALL EMPLOYERS FOR THE PAST FIVE (5) YEARS BEGINNING FROM MOST RECENT:

EMPLOYER	ADDRESS	POSITION	DATES OF EMPLOYMENT	PHONE #

D. DESCRIBE ANY VOLUNTEER WORK THAT YOU MAY HAVE DONE (MAY USE ADDITIONAL PAGE IF NECESSARY)

E. STATEMENT OF INTENT

ON A SEPARATE SHEET OF PAPER, IN 200 WORDS OR LESS, STATE WHY YOU CHOSE A CAREER IN THE HEALTH CARE PROFESSION AND OUTLINE YOUR SPECIFIC CAREER GOALS IN MEDICAL IMAGING.

F. LETTERS OF REFERENCE

ALL APPLICANTS TO THE PROGRAM ARE REQUIRED TO SUBMIT AT LEAST TWO LETTERS OF REFERENCE.

- **EDUCATIONAL REFERENCE: CHOOSE A PERSON FAMILIAR WITH YOUR EDUCATIONAL QUALIFICATIONS AND YOUR POTENTIAL FOR SUCCESS IN THE FIELD OF ECHOCARDIOGRAPHY. REFERENCES MAY INCLUDE CURRENT OR FORMER TEACHERS OR PROFESSORS.**
- **WORK REFERENCE: CHOOSE A PERSON FAMILIAR WITH YOUR PROFESSIONAL QUALIFICATIONS AND YOUR POTENTIAL FOR SUCCESS IN THE FIELD OF ECHOCARDIOGRAPHY. REFERENCES MAY INCLUDE EMPLOYERS OR SUPERVISORS.**

I HEREBY CERTIFY THAT THE FACTS 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 SHALL BE CONSIDERED SUFFICIENT CAUSE FOR DISMISSAL FROM THE PROGRAM.

I ALSO UNDERSTAND THAT ADMISSION INTO THE ECHOCARDIOGRAPHY PROGRAM CONSTITUTES ADHERENCE TO ALL HOSPITAL AND SCHOOL POLICES AND REGULATIONS.

IF SELECTED FOR THE ECHOCARDIOGRAPHY PROGRAM, I AGREE TO HAVE A MEDICAL EXAMINATION AT THE JOHNS HOPKINS HOSPITAL DURING ADMISSION / ENROLLMENT.

I UNDERSTAND THAT I WILL BE REQUIRED TO UNDERGO A CRIMINAL BACKGROUND CHECK AND DRUG TESTING UPON ACCEPTANCE INTO THE PROGRAM.

SIGNATURE: _____ DATE: _____

THE JOHNS HOPKINS SCHOOL OF CARDIAC SONOGRAPHY ADMITS STUDENTS OF ANY RACE, COLOR, SEX, DISABILITY, AND NATIONAL OR ETHNIC ORIGIN TO ALL OF THE RIGHTS, PRIVILEGES, PROGRAM BENEFITS AND ACTIVITIES GENERALLY ACCORDED OR MADE AVAILABLE TO STUDENTS AT THE MEDICAL IMAGING SCHOOL.

IN THE SPACE BELOW, PLEASE TELL US HOW YOU HEARD ABOUT THE JOHNS HOPKINS HOSPITAL SCHOOLS OF MEDICAL IMAGING. THANK YOU!