RADIOLOGIC TECHNOLOGY APPLICATION

- January 17 – February 21
- Incomplete Applications will not be processed

Print Name:____
Last First

Social Security #xxx-xx-______________________ PCC Student ID#______________________

PCC student Identification numbers are not accepted in place of a social security number

Address:____

City:_________________________________ Zip:_______________________________

Cell Phone #__________________________ Home Phone #______________________

Email:____

Applicants will be notified of their status by email.

One *official* transcript of all colleges attended including PCC must be submitted with this application. A second *official* transcript must be sent to the Records Office upon acceptance to the program. The Health Sciences Division will not retrieve scanned transcripts.

College degree(s) received: ☐ Associates ☐ Bachelors ☐ Masters

List all colleges attended: (1)__________________________ (2)__________________________

(3)__________________________ (4)__________________________

(5)__________________________ (6)__________________________

Course	College	Course Title and Number	Units	Grade	Term/Year
Program Prerequisites:					
Intermediate Algebra					
Medical Terminology					
Anatomy 25					
Physiology 1					
Physics 10					
Physics 10L					
Chemistry 2A					
General Education Courses for the AA/AS Degree: (a degree is required to take the licensing exam)					
English 1A					

Speech 1 or 10					
Social Science course (3 units)					
Humanities course (3 Units)					
American Institutions 125*					
Political Science					
U.S. History					
Physical Activity					
Physical Activity					

*American Institutions can be taken in place of Political Science and U.S. History requirement.

Are you a U.S. Veteran or spouse of a U.S. Veteran? ☐ YES (please provide a copy of your DD214)

☐ No I am not a U.S. Veteran or spouse of a U.S. Veteran

Participation involves off campus clinical facilities. Students must provide their own transportation to off campus sites. Some off campus sites require Homeland security screenings and verification of legal status.

Upon admission to the program students are required to complete a health clearance and criminal background check in order to attend clinical experiences which are required for program completion. Details regarding these clearances will be provided to selected candidates with the acceptance packet. Hospitals and health care providers may deny access to clinical experiences based on certain criminal background findings. This would restrict the student from admission as the required clinical experiences would not be available. Students who have questions or concerns about the background check are encouraged to make an appointment with the Program Director.

Submission of an application does not guarantee acceptance.

My signature below indicates that I have provided true and accurate information on this application and that I understand that final acceptance to the program will be based on my background check and completion of required documents.

____ ________________________

Signature Date

Applications may be delivered in person or mailed to:

Pasadena City College
Health Sciences Division B6
3035 East Foothill Blvd.
Pasadena, CA 91107
Attn: Radiology Technology Program

PASADENA CITY COLLEGE
RADIOLOGIC TECHNOLOGY
Volunteer Hours Verification Form – 36 required hours

Applicant Instructions:

1. Include this form with your application.
2. All signatures and phone numbers must be verifiable.
3. Missing information may be cause for non-consideration.
4. You must break down the hours between general x-ray and modalities. If you observe more than one modality in a day, separate the hours for verification purposes.

Applicant Name:____________________________________ Date:______________________

Name of Clinical Site____

Clinical Site Address:____

Clinical Site Phone Number of the Radiology Department__________________________

Supervisor Instructions:

1. Print your name and initial for verification purposes.
2. Provide a work number where you can be contacted.
3. Provide a work email address where you can be contacted.

Supervisor's Name:_________________________________ Date:______________________

Work Phone:__________________________ Work Email:______________________________

Date MM/DD/YY	Hours (8:00 – 4:00 = 8 hours)	Modality (General x-ray, CT, MRI, US)	Initials of Tech
		Total Volunteer Hours:	

The following information is voluntary and is used as summary information only to ensure that the selection process has not disproportionately discriminated against any group.

1. Please indicate your **Ethnic Background**:

ETHNIC BACKGROUND	
_____ASIAN	**____CAUCASIAN – NON HISPANIC**
_____AFRICAN AMERICAN	**____AMERICAN INDIAN**
_____HISPANIC	**____FILIPINO**
_____OTHER	**____PACIFIC ISLANDER**

2. Please indicate your **Gender**:

_______Male ______Female

3. Please indicate your current **Age Range**:

_____18 to 25 _____ 26 to 30 _____31 to 45 _____46 and older

4. Have you ever previously been enrolled in a radiology program?

_____Yes _____ No

5. If you answered yes to number 4, where and when?

____