

OSF Saint Francis Medical Center
School of Radiography
 530 N.E. Glen Oak Avenue
 Peoria, Illinois 61637

Application for appointment as Student Radiographer

A. PERSONAL DATA

Name _____
 Last First M.I. Previous Name (if applicable)

Address _____
 Street Address Telephone _____

City State Zip S.S.# _____

- Will you be at least 18 years of age by the program start date of the year for which you are applying?
 ___YES ___NO

Person to contact in case of emergency _____
 Name

Address City/State/Zip Telephone

B. EDUCATION

	Name & Location of School	Dates Attended/Degree
High School		
College		
College		
Other		

Please list below the **course(s) you are currently enrolled in or plan to take** in upcoming quarters/semesters:

College Name/Location	Quarter or Semester/Year	Course name/number
e.g. Illinois Central College, E. Peoria IL	Fall, 201X	Anatomy & Physiology w/ Lab / BIOL 140

C. EMPLOYMENT

Please list last employer first. Account for every year.

Name/Address of employers	Type of Business	Employment dates	Position Held	Reason for leaving

D. PHYSICAL

As a Radiography student, you will be expected to *learn*, then *perform* the following tasks:

- move, lift, assist and transfer patients safely
- move, adjust and manipulate a variety of x-ray equipment, including mobile equipment
- communicate effectively with patients in order to listen, instruct and respond
- provide physical and emotional support to patients
- physically respond to emergency patient needs
- visually review radiographs to identify shades of gray and anatomy in order to evaluate their quality

Are you aware of any reason you would NOT be able to perform these tasks, with or without reasonable accommodations? ___YES ___NO

(If unable to perform task(s), please attach an explanation on a separate sheet.)

E. CHARACTER REFERENCES

List names/occupations of *three* character references you wish to use, two from recent employers and/or teachers and one personal. *(Give reference forms to these persons.)*

1. _____
2. _____
3. _____

F. SIGNATURE

I, _____, certify that the information on this application is true and accurate to the best of my knowledge.

Applicant Signature

Date

EVALUATION OF APPLICANT PERFORMANCE AND POTENTIAL

1. How long have you known this applicant? In what capacity?

2. What are this applicant's strengths and weaknesses? If possible, give illustrations.

Strengths:

Weaknesses:

3. What activities/experiences have developed character in this applicant?

4. Please rate this person in the following categories:

	Excellent	Good	Fair	Poor
Attendance/Promptness				
Critical Thinking Skills				
Self-Confidence				
Self Discipline				
Multi-tasking Ability				

Additional Comments:

If the applicant signature appears under the waiver on the front of this form, your evaluation will not be reviewed by the applicant; please mail directly to the address below.

If the applicant has *not* signed the waiver and enrolls in this school, the applicant will have the right to review the evaluation.

Date: _____

Signature: _____

Position: _____

Address: _____

If the waiver is signed on page 1, please return this form directly to:

Program Director, School of Radiography
OSF Saint Francis Medical Center
530 NE Glen Oak Avenue
Peoria, Illinois 61637