UNIVERSITY OF ALASKA ANCHORAGE
MEDICAL IMAGING SCIENCES DEPARTMENT
Proof of Eligibility

Last Name______________________ First Name ______________________ UAID ________________

1. **I am admitted as a degree-seeking student at the University of Alaska Anchorage**

   YES ☐ **NO** ☐

2. **I have completed or will complete all the prerequisite courses by the May 15th deadline.**

   (Medical Terminology, Anatomy & Physiology I, and Anatomy & Physiology II)

   YES ☐ **NO** ☐

3. **I have above a cumulative GPA of 3.0 (including UA GPA and additional College GPAs)**

   YES ☐ **NO** ☐

If you answered 'NO' to any of the above questions you are not eligible to apply to the Radiologic Technology Program. Your application will not be reviewed.

4. **I am submitting a complete application (IN THE ORDER THEY APPEAR BELOW) to include the following:**

   - ☐ **Main Application Form**
   - ☐ **Prerequisite and General Education Requirement Course Information**
     ☐ **(Official transcripts from all other colleges and universities have been submitted to UAA Enrollment Services.)**
   - ☐ **Narrative Responses** (1-2 pages, size 12 Times New Roman font, 1.5 spacing)
   - ☐ **Completed, signed and certified Immunization Record form**
   - ☐ **Clinical Observation Form**
   - ☐ **Clinical Observation Essay** (1-2 pages, size 12 Times New Roman font, 1.5 spacing)
   - ☐ **Proof of CPR/BLS Certification accredited by the American Heart Association** (including adult, child, infant, and AED) **included with application** (photocopy of certification card)

I understand that if any of the above listed items are not included in my application, it will not be considered complete and may not be reviewed by the Radiologic Technology admissions committee.

________________________________ ________________
Signature Date

UNIVERSITY OF ALASKA ANCHORAGE
MEDICAL IMAGING SCIENCES DEPARTMENT
Radiologic Technology Application Form

THE DEADLINE TO APPLY FOR FULL MAJOR STATUS IS MAY 15TH.
THE DEADLINE TO APPLY FOR ADMISSION TO UAA IS NOVEMBER 1ST FOR SPRING ADMISSION

A. SITE SELECTION- *SELECT ONLY ONE OF THE FOLLOWING*

PLEASE CHECK THE PROGRAM WEBISTE FOR AVAILABLE SITES FOR YOUR APPLICATION YEAR.

☐ UAA Anchorage Campus
☐ UAA/KPC Kenai Campus
☐ UAF Fairbanks Campus
☐ UAF Bethel Campus
☐ UAS Ketchikan Campus
☐ UAS Juneau Campus

B. GENERAL INFORMATION- *PLEASE TYPE*

Last Name________________________________ First Name __________________________ M.I. ________

DOB____________________________________ UA SID NUMBER: ___________________________

Full Mailing Address (including city and zip code):__________________ ______________________________

____

Home Phone ________________ Cell Phone __________________ Email_________________________

If you will be submitting documents and/or records under a previous name, please list the previous names as they appear on those document(s)/record(s).

____ ____

Are you a United States citizen or legal resident? **YES** ☐ **NO** ☐ (Proof of legal residency may be required for UAA enrollment)	Have you been an Alaskan resident for the past year? **YES**☐ **NO** ☐ If no, what state are you currently a resident of?

Have you applied to the Radiologic Technology Program previously? **YES**☐ **NO** ☐

If yes, what year(s) did you previously apply? ____

C. EDUCATION- *GED/HIGH SCHOOL and COLLEGE*

Are you formally admitted to a degree seeking program at UAA? **YES** ☐ **NO**☐

If yes, which degree program? ____

Last Name_______________________ First Name _______________________ UAID ________________

Please ensure all ***official*** transcripts from all previous colleges and universities attended have been submitted to UAA Enrollment Services prior to the application deadline.

Name of School	**City/State**	**Dates Attended**	**Diploma/Degree Received**	**Cumulative GPA**

D. <u>PROFESSIONAL/WORK EXPERIENCE</u> (Please list work experience beginning with most recent position)

Name of Employer	**Position Held**	**Employment Dates**	**Reason for Leaving**

All applicants <u>MUST</u> be able to lift 50lbs. Are you able to lift 50lbs without the assistance of others?

YES ☐ **NO** ☐

Do you have any health problems or physical disabilities that may potentially compromise the health of clinical patients or classmates, or any that would impact your ability to perform any functions/tasks/procedures in this program? *(Diagnosis of a contagious disease or health problem is not an automatic bar for consideration or selection. This information could help us plan for provision of additional protection, if needed, or support to accommodate needs.)*

YES ☐ **NO** ☐

(Please explain – use another page/attachment if needed)

Last Name______________________ First Name ______________________ UAID ________________

Optional Information

(Ethnic origin is requested for compliance with Title IV of the Civil Right Act of 1964. This information may be used to obtain statistical information necessary to receive special funding.)

Ethnic Origin

☐ White, Non-Hispanic	☐ American Indian	☐ Black, Non-Hispanic	☐ Asian, Pacific Islander
☐ Hispanic	☐ Inuit	☐ Yupik	☐ Alaskan Indian, Athabascan
☐ Alaskan Aleut	☐ Other	☐ Alaskan Indian, Southeast	

VA/Military Status, if applicable			**Gender**
☐ Active Duty/Army	☐ Active Duty/Air Force	☐ Receiving Veteran Benefits	☐ Male
☐ Active Duty/Navy	☐ Active Duty/Marine	☐ Active Duty/Coast Guard	☐ Female
☐ Dependent Spouse	☐ Dependent Child	☐ Other	

E. **NARRATIVE RESPONSES:** In your own words, please answer the following questions and attach your essay to the application.

1. Describe what influenced your decision to choose this program.
2. Describe what you hope/expect to get out of this program.

F. **PRE-IMMUNIZATION RECORD** *(attached)*
Please have the attached immunization form completed by your health care provider. See application instructions for additional information.

G. **CLINICAL OBSERVATION FORM** *(attached)*
Please complete the attached clinical observation form including the signature of the supervising radiologic technologist.

H. **CLINICAL OBSERVATION ESSAY:** In your own words, please describe your experience during your clinical observation.

I. **PROOF OF FIRST AID/ CPR CERTIFICATION:** Submit a copy of your current CPR or BLS certification card with your application with the expiration date clearly visible. First Aid/CPR Training Certification must include Adult, Child, Infant, and AED.

Please note program will require a criminal background check upon acceptance.

UAA is an Equal Opportunity/Affirmative Action employer and educational institution.

Please feel free to contact the Program Assistant at anceb1@uaa.alaska.edu 907-786-6940 with any questions or if you would like to meet with program faculty to discuss program requirements.

Please return this completed application to:
University of Alaska Anchorage
Medical Imaging Sciences Department
3211 Providence Dr., AHS 160
Anchorage, AK 99508

UNIVERSITY OF ALASKA ANCHORAGE
MEDICAL IMAGING SCIENCES DEPARTMENT
Prerequisite and General Education Requirement Course Information

Last Name______________________ First Name ______________________ UAID ________________

Please complete the following form with information. The information provided on this form, including grade information must be supported by official transcripts on file with UAA Enrollment Services.

	Name of School	**Term Taken**	**Course Name** (if different from UAA title)	**Course Number**	**Grade**
BIOL A111 (or equivalent)					
BIOL A112 (or equivalent)					
MA A101 (or equivalent)					
The below listed courses are required Degree Requirements and are required for graduation. These courses are not required for admission into the program, but are highly recommended.					
ENGL A111 (or equivalent)					
200 Level ENGL (or equivalent)					
MATH A105 or A107 (or equivalent)					
COMM A111, 235, 237, or 241 (or equivalent)					
PSY A111, 150, 153 or SOC A101 (or equivalent)					

If you have transfer credits from another school, have you submitted them to UAA Enrollment Services for transfer credit evaluation? **YES**☐ **NO** ☐

For the graduation purposes, all official transcripts must be submitted to UAA Enrollment Services for evaluation from all schools other than UAA (including UAF and UAS).

Updated 10/17/2011

UNIVERSITY OF ALASKA ANCHORAGE
MEDICAL IMAGING SCIENCES DEPARTMENT
Pre-Entrance Immunization Record

**** Each immunization requires Health Care Provider documentation ****

Student Name ____________________________ Student ID # __________________________

All students seeking admissions to the full-major Radiologic Technology program must show proof of the following immunizations in order to be admitted. Please have your health care provider certify or sign this form, verifying your immunity. Copies of shot records are not necessary. Application is not considered completed unless this form is signed by your provider.

	Immunization Date	OR	Titer Results	Provider Signature (Required)
1. Rubella (German Measles)	________		________	________
2. Rubeola (Measles)	________		________	________
3. Varicella (Chicken Pox)	________		________	________
4. Hepatitis B				
#1	________			________
#2	________			________
#3	________			________
Immunity Titer			________	________
5. Hepatitis A				
#1	________			________
#2	________			________
Immunity Titer			________	________

If any of the **above** immunizations are more than 10 years old, a titer showing immunity is required.

	Immunization Date	OR	Titer Results	Provider Signature (Required)
6. Tetnus/Diptheria/Pertussis (Tdap – must be updated every 10 years)	________			________
7. Freedom from Tuberculosis by Mantoux method PPD (must be updated annually) or Chest X-Ray	________		________	________
8. Annual HIV Test (results **NOT** required, documentation only.)				________

For your own information and protection, an HIV screen and physical exam is highly recommended.

This form is required to participate in all of the practicum courses. You cannot attend a clinical site without current immunization records.

Updated 10/17/2011

UNIVERSITY OF ALASKA ANCHORAGE
MEDICAL IMAGING SCIENCES DEPARTMENT
Clinical Observation Form

See *Application Instructions* for a list of approved observation sites and contact information for scheduling purposes. If you wish to observe examinations at a hospital, clinic, or private office that is not listed please contact the Medical Imaging Sciences Department for approval. ***Clinical observations must be scheduled in two eight-hour blocks.***

Applicant's Name: ____

Facility(s) Visited: ____

Date(s) & Times Visited: ____

Total Number of Observation Hours: ____

It is recommended that the following procedures be observed:

(Please check once observed)

1. Extremities (2 exams; indicate): __________________ / ___________________
2. One spine exam: ☐ Cervical ☐ Thoracic ☐ Lumbar/Sacral
3. Gastrointestinal: ☐ *Upper gastrointestinal ☐ Barium enema
4. Thorax ☐ (chest)
5. Mobile Radiography (indicate): _______________
6. Emergency Department (2 procedures): ________________ / _______________
7. Other _________________________ _______________________________

Supervising radiographer please sign below:

____ ___________

Supervising R.T.(R)/Chief Technologist/Facility(ies) Date of the Visit(s)

Must wear a dosimeter if observing in the room
(Observation is contingent upon patient permission)

Updated 10/17/2011