RADIOGRAPHY PROGRAM APPLICATION CHECKLIST

Name_____ Student ID# _____

The following are **minimum** requirements for consideration of the application for admission to the Radiography Program. **Complete each requirement and initial beside each requirement that has been met.** Please submit, in person, completed application for required signature to an academic advisor on one of the college's campuses (Winter Haven, Lakeland, JD Alexander Center, or Airside Center West)

****Please do not mail or fax this application as its receipt will not be guaranteed. Failure to complete all requirements will dismiss the applicant from the selection process for the upcoming class.**

Requirements for application to be accepted:

_____ Admission to Polk State College with all required admission documents received by the Registrar's office.

_____ Official transcripts from ALL colleges/universities attended**. ****At the time of program application submission, transcripts must be received, evaluated by Student Services, and posted to student's Polk State College transcript.**

_____ Current overall cumulative GPA, after all transcripts have been posted to the Polk State College system, **must** be a 2.0 or higher.

_____ Required prerequisite courses **COMPLETED** (not in progress) with a "C" or better (mark final course grade on line beside each course listed below). Application cannot be submitted without a final grade in these courses.

_____ ENC 1101 College Composition
_____ HSC 1531 Medical Terminology
_____ MAC 1105 College Algebra (or higher)
_____ BSC 2085C Human Anatomy & Physiology I
_____ BSC 2086C Human Anatomy & Physiology II

_____ Applicant's degree audit attached to the end of this application

_____ Attached verification of licensure and/or healthcare employment (if applicable) No consideration given for healthcare experience without attached documentation.

I have completed all of the above requirements and attest that I am submitting a completed application.

Applicant's Signature _____ Date _____

Application reviewed by Academic Advisor for completeness and accuracy.

Academic Advisor Signature_____ Date Stamp _____

****Receipt given to student (Advisor initials) _____**

Revised, 2018

POLK STATE COLLEGE

APPLICATION FOR ACCEPTANCE

RADIOGRAPHY PROGRAM

STUDENT INFORMATION:

Name: _____

Last **First** **Middle**

Former Name(s): _____

Student ID #: _____

Mailing Address: _____

_____

City State Zip County

Phone Numbers: Home_____ Cell_____

E-mail:_____ Work_____

Have you previously been enrolled in a Health Science program at Polk State College or any other college that prepares graduates to sit for Licensure or Certification?

_____ Yes, at Polk State College _____ Yes, at another school _____ No

If yes, please explain:

_____

_____

Do you currently hold any health professional licenses or certificates? _____Yes _____ No

If yes, please indicate type, licensure or certificate number, and expiration date_____

_____

Required: Attach a current copy of license or certificate to this application

Name_____ **Student ID#** _____

Health Care Employment (Submit verification of employment on official letterhead**)**
**No consideration given for healthcare experience without attached documentation.

If you are currently employed or have recently been employed (within 5 years) by a health care facility/provider, please provide the following information:

Employer: _____ Supervisor: _____

Address: _____

Phone: _____

Position: _____ Dates Employed: _____

Specific Job Duties: _____

_____

Employer: _____ Supervisor: _____

Address: _____

Phone: _____

Position: _____ Dates Employed: _____

Specific Job Duties: _____

_____

Employer: _____ Supervisor: _____

Address: _____

Phone: _____

Position: _____ Dates Employed: _____

Specific Job Duties: _____

_____

Name_____ **Student ID#** _____

LICENSURE INFORMATION:

State and national regulations provide that the denial of a license/credential may occur if an individual is habitually intemperate, addicted to, or is found to be in illegal possession or involved in the sale of distribution of habit forming drugs, and/or is unfit or incompetent by reason of gross negligence, physical or mental condition or other like causes which could result in behavior that interferes in his/her practice as a health professional.

Please read the following questions below. A "yes" answer could result in the denial of a license/credential (**Note:** you are not required to write a yes or no beside the questions).

1. Have you ever been convicted or have you entered a no contest or guilty plea-regardless of adjudication-offense other than a minor traffic violation?

2. Have you ever been denied or is there now any proceeding to deny your application for a license to practice a health profession in Florida or any other jurisdiction?

3. Have you ever had a disciplinary action taken against your license to practice a health profession by the licensing authority in Florida or any other jurisdiction?

4. Have you ever surrendered a license to practice in a health profession in Florida or any other jurisdiction while any such disciplinary charges were pending against you?

**I certify that I have read and understand the information indicated above regarding licensure/credentialing as a health professional at both the state and national level.

Applicant's Signature _____ Date _____

Any questions, please contact:

Beth Luckett
Radiography Program Director
Polk State College, Airside Center
3515 Aviation Drive
Lakeland, FL 33811
863-669-2901
bluckett@polk.edu

Name_____ **Student ID#** _____

****THIS CERTIFICATION IS TO BE COMPLETED BY ALL APPLICANTS**

I hereby certify that the facts set forth in this application are true and complete to the best of my knowledge. I understand that discovery of any falsification of this information will result in denial of admission or prompt dismissal from the program. Polk State College is hereby authorized during the selection process and/or during my tenure as a student, if admitted, to make any investigation that is deemed necessary concerning the above information with regard to my suitability to practice as a health professional.

Applicant's Printed Name _____ Date _____

Applicant's Signature _____

(To be signed in presence of notary)

Sworn to and subscribed before me at _____

This _____ day of _____, 20 _____

_____
Notary Public or other officer authorized to take acknowledgement.

Personally Known_____ *OR* Produced Identification _____

Type of Identification Produced _____

Name_____ **Student ID#** _____

Additional Information

Applicants are admitted to the Radiography Program using a selective admission process. The selection committee utilizes a point system as a GUIDE in the selection of qualified students for the program (contact Program Director with questions). The following areas evaluated by the committee include:

- **College GPA**
- **Prerequisite GPA**
- **Polk County Residency**
- **Related Experience (No consideration given for healthcare experience without attached documentation**.)
- **Corequisite Courses Completed (please put final grade in space below beside each course completed and on transcript)**

  _____ HLP1081 Wellness Concepts
  _____ CGS1061 Intro to Computers and Information Systems
  _____ PHI2600 Ethics
  _____ Social Science approved for General Education

****At the time of acceptance into the Radiography Program, the applicant will be notified by mail with additional information about the Radiography Program's mandatory orientation date/time. During this required orientation, additional program information and requirements will be presented to the student that include:**

- Physical and Immunizations
- Background Check
- Drug Screen
- Affidavit of Good Moral Character
- Current CPR
- Uniform Requirements
- Program textbooks and course registration for program (Radiography Program begins spring term)

Any questions, please contact:

Beth Luckett
Radiography Program Director
Polk State College, Airside Center West
3515 Aviation Drive
Lakeland, FL 33811
863-669-2901
bluckett@polk.edu

Jaime Selph
Radiography Program Clinical Coordinator
Polk State College, Airside Center West
3515 Aviation Drive
Lakeland, FL 33811
863-669-4959
jselph@polk.edu