

APPLICATION FOR ADMISSION

ALLIED HEALTH PROGRAMS



CHECK BELOW THE CAREER PROGRAM TO WHICH YOU ARE APPLYING:

RADIOGRAPHY
\$50.00 Application Fee

RADIATION THERAPY
\$50.00 Application Fee

PHLEBOTOMY
\$50.00 Application Fee

MEDICAL TECHNOLOGY (CERTIFICATE)
\$50.00 Application Fee

COMPLETE ALL INFORMATION AS REQUESTED ON THE APPLICATION. PLEASE PRINT OR TYPE.
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

Name _____
Last First Middle

Mailing Address _____

City _____ State _____ Zip _____

Residence Address (If different from Mailing Address) _____

City _____ State _____ Zip _____

Contact Phone Number (_____) _____ E-mail Address _____

START WITH YOUR MOST RECENT EMPLOYMENT
PLEASE GIVE INFORMATION CONCERNING PREVIOUS WORK EXPERIENCE:

1. Name of present or most recent Employer _____
Address _____ City _____ State _____ Zip Code _____
Supervisor _____ Phone Number () _____
Position _____ Dates Worked: From _____ To _____
Reason for leaving _____

2. Name of previous Employer _____
Address _____ City _____ State _____ Zip Code _____
Supervisor _____ Phone Number () _____
Position _____ Dates Worked: From _____ To _____
Reason for leaving _____

3. Name of previous Employer _____
Address _____ City _____ State _____ Zip Code _____
Supervisor _____ Phone Number () _____
Position _____ Dates Worked: From _____ To _____
Reason for leaving _____

PLEASE PROVIDE INFORMATION CONCERNING HIGH SCHOOL AND/OR OTHER EDUCATIONAL FACILITIES ATTENDED:

Name of **High School** _____ Highest Grade Completed _____ Graduation Date _____
Address _____ City _____ State _____ Zip Code _____

College or University _____ Highest Year Completed _____ Graduation Date _____
Address _____ City _____ State _____ Zip Code _____

Other – Include name, address, phone number, course of study, and date/s.

DESCRIBE YOUR EXTRACURRICULAR ACTIVITIES, HOBBIES, STUDIES
(PARTICULARLY THOSE WHICH DEMONSTRATE AN ACTIVE INTEREST IN HEALTH CARE)

HAVE YOU EVER BEEN CONVICTED OF A CRIME? Criminal background checks may be performed.
No _____ Yes _____ Pending _____ **If yes or pending, please explain below:**

GIVE THE NAMES AND ADDRESSES OF FOUR PEOPLE WHOM WE CAN CONTACT FOR REFERENCES.

DO NOT LIST RELATIVES OR PERSONAL FRIENDS

You may include a teacher, counselor, or employer.

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone () _____

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone () _____

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone () _____

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone () _____

OFFICIAL COPIES OF ALL HIGH SCHOOL AND COLLEGE TRANSCRIPTS MUST BE SENT DIRECTLY FROM THE HIGH SCHOOL AND COLLEGE(S) TO:

**HARTFORD HOSPITAL - ALLIED HEALTH
ERD BUILDING – 8th Floor
560 HUDSON STREET
HARTFORD, CT. 06106**

ATTENTION: _____ Program (program to which you are applying)

Hartford Hospital School of Allied Health does not discriminate on the basis of race, religion, color, sex, national and ethnic origin or handicap in the administration of its educational, admissions, or scholarship policies.

THIS APPLICATION WILL NOT BE PROCESSED WITHOUT THE INCLUSION OF THE APPROPRIATE APPLICATION FEE.

PLEASE MAKE YOUR CHECK PAYABLE TO: HARTFORD HOSPITAL

We want to know you better as a person. Describe, **in your own handwriting**, and in **500 words or less**, the specific experiences, which influenced your decision to pursue the health career for which you have applied. Provide additional paper as needed and attach it to the application.

I attest that my answers to the above questions are true and that misrepresentations or omission of facts may disqualify me or cause my termination.

Date _____ Signature _____

Please be advised that all information you provide will be shared with the members of the program's Admission Committee and will subsequently be kept on file in the Allied Health office.