Philadelphia School of Radiologic Technology

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

160 East Erie Ave. Philadelphia, PA 19134

Admission Application

(Please Type or Print in Ink)

Personal Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____

Emergency Contact_____ Phone: (_____) _____

Social Security Number: _____

Email: _____

Education History

Most Recent College

Name: _____

Address: _____

Dates of Attendance: _____

Degree Awarded & Graduation Date: _____

Other College

Name: _____

Address: _____

Dates of Attendance: _____

Degree Awarded & Graduation Date: _____

Other Post-Secondary Education

Institution: _____

Dates of Attendance: _____

Previous Radiography Education

Have you received any? ☐ Yes ☐ No

If yes, where? _____

Employment Experience

Most Recent Employer

Name: _____

Address: _____

Phone: (_____) _____

Date of Employment: _____

Nature of Employment: _____

Other Employer

Name: _____

Address: _____

Phone: (_____) _____

Date of Employment: _____

Nature of Employment: _____

Legal Disclosure

Nondiscriminatory Policy

The School does not discriminate based on race, color, religion, sex, sexual preference, disability, age, or national origin in the administration of educational or admissions policies.

Applicant Certification

I hereby apply for admission to the School of Radiologic Technology of St. Christopher's Hospital for Children. I certify that the information provided is true and complete. I understand that the omission or falsification of information may result in rejection or dismissal. If admitted, I agree to abide by all school policies.

Signature of Applicant: _____ Date: _____