MRI, CT & Mammography Technologist Certificate Program Application

Student Information

Please type or print neatly in blue or black ink

Last Name First Name Middle Initial Previous Last Name(s)

Male ❒ Female ❒ Email address _____
(Communication will be conducted primarily through email & a valid email account is required)

Social Security Number Date of Birth (mm/dd/yyyy)

Current mailing address number and street City State Zip

Home Phone Alternate Phone Cell Phone

Education Information

List your educational background beginning with the most recent. Please print clearly.

Institution	State	Dates of attendance	Degree earned

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Employment Information

List your work experiences in health care institutions beginning with the most recent. Please print clearly.

Employer	Position	Start/End Dates	Reason for leaving.

Certifications/Special Skills/Awards

Please include a copy of certification documenting the date of ARRT(R), ARRT(N), ARRT(T), NMTCB, RDMS or other registry exam.

Please list all certifications
Please list any special skills or awards
Please list MRI Courses/CT Courses or Cross-Sectional Anatomy Courses

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References

Please list the name of (2) past instructors, supervisors, or managers for which you will be submitting the ***Reference Evaluation Form*** for evaluation**.** Please print clearly.

Name	**Title/Position**
Relationship to you:	
Name	**Title/Position**
Relationship to you:	

Application Fee Payment Information

A $25.00 non-refundable application fee must be submitted with completed application.

Payment Method *(please select one)*

_____Cash ____Check* ___Credit Card**

**If paying by check, please make check payable to Johnson College and mark "MRI/CT" in memo line.*

***If paying by credit card, please complete the following:*

Name (as it appears on the card):_____

Credit Card Type: ____MasterCard ____Visa _____Discover _____American Express

Credit Card Number: _____

Expiration Date (mm/yyyy): _____

Security Code (3 digits on back of card): _____

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Criminal Background / Drug Testing

Have you ever been convicted of a felony or misdemeanor? ☐ YES ☐ NO
If yes, please explain: _____

Applicants accepted into the MRI and CT Technologist Certificate Program must submit to the following screening exams or provide documentation that their certifications are current and do not lapse during the clinical experience no later than November 1st. Students are financially responsible for exam costs:

- 2-Step Mantoux
- Urine Drug Screen
- PA State Police Criminal Record Check
- FBI – Federal Criminal History Clearance
- PA Child Abuse History Clearance
- CPR (AHA)

Please note: Failure to pass the background checks and/or drug screenings will prohibit a student from participating in the clinical experience and no tuition refunds will be given.

Student Acknowledgement / Signature

I understand that students completing the MRI/CT Technologist Certificate Program have no guarantees of employment from their clinical training site. *(Unless otherwise employed by their clinical site)* I understand that the relationship of the clinical site to the student ends at the successful completion of the MRI/CT clinical course.

I understand that upon successful completion of the MRI/CT Technologist Certificate Program, students will receive a Johnson College certificate of completion and will be eligible to sit for the ARRT MRI or CT certification exam. Participation in this program does not equate to Certification nor guarantee successful passing of the exam.

I authorize Johnson College, Continuing Education Department, to verify information related to my application. I understand that being accepted by, and continuing in the MRI/CT Technologist Certificate Program depends on the truthfulness of my application, general questionnaire, safety questionnaire and successful completion of a criminal background check and drug screening. I have read and understand the admission criteria for the MRI/CT Technologist Certificate Program. I understand that it is my responsibility to meet all program and application criteria. I verify that all statements on this application are complete and true. I understand that falsification of any information may lead to disqualification or dismissal from the program.

_____
Signature

Date

All application materials must be hand-delivered or mailed to:

Johnson College
Continuing Education Department
3427 N. Main Ave.
Scranton, PA 18508

MRI and CT Technologist Certificate Program
General Questionnaire

Are you only interested in MRI training?	☐ **YES**	☐ **NO**
Are you only interested in CT training?	☐ **YES**	☐ **NO**
Are you only interested in Mammography training?	☐ **YES**	☐ **NO**
Are you willing to travel within 90 miles of Johnson College for a clinical site for Track 1?	☐ **YES**	☐ **NO**
Are you to willing secure your own clinical site for Track 2?	☐ **YES** **Where:**	☐ **NO**
Are you currently employed where you will be doing Clinical for Track 3?	☐ **YES** **Where:**	☐ **NO**
Do you have reliable transportation?	☐ **YES**	☐ **NO**
Do you have a valid driver's license?	☐ **YES**	☐ **NO**
Are you available for Clinical 2 days per week, 8 hours per day?	☐ **YES**	☐ **NO**
Do you have reliable Internet connection and computer for accessing online curriculum?	☐ **YES**	☐ **NO**
Are you willing to secure all the required clearances?	☐ **YES**	☐ **NO**
Did you review the Frequently Asked Questions on the JC website?	☐ **YES**	☐ **NO**

1.) WORK EXPERIENCE

Years as Registered Technologist

> 10 years ___

5-10 years ___

3-5 years ___

1-2 years ___

Recent Graduate ___

Length of Service with Employers

> 5 years ___

3-5 years ___

2-3 years ___

1-2 years ___

Student Tech/Newly Hired ___

2.) CROSS SECTIONAL/MODALITY WORK EXPERIENCE

MRI Tech Work Experience

> 2 years ___

> 1-2 years ___

1 year ___

CT Tech Work Experience

> 2 years ___

> 1-2 years ___

1 year ___

US /NM /RadTh Tech work experience

> 2 years ___

> 1-2 years ___

1 year ___

3.) ADDITIONAL EDUCATION ** MR Physics ___ Cross-Sectional Anatomy ___
***Transcripts must be provided*

4.) REFERENCE LETTERS
References must be from current and prior supervisors of your work **within the medical field.**

The Radiologic Technology department reserves the right to consider other aspects of the candidate's application. Please note: All requirements and selection criteria are subject to change on a yearly basis.

I hereby affirm that all the information supplied on this questionnaire is accurate and complete. I understand that some NO answers may prohibit me from entering the JC MRI and CT Technologist Certificate Program.

Applicant Signature: _____ Date: _____

MRI Technologist Certificate Safety Questionnaire

(This safety questionnaire is for MRI applicants only)

Due to work environments that have high magnetic field strengths, it is not safe for operators to have certain medical conditions or implanted devices within their bodies. Complete the following questionnaire and include this form with you application materials.

DO YOU HAVE OR ARE YOU?		
Pregnant	☐ **YES**	☐ **NO**
Require hearing aids to communicate clearly	☐ **YES**	☐ **NO**
Cardiac Pacemaker	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Implanted Cardiac Defibrillator	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Implanted Neurostimulator / Electrodes / Wires	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Any type of Magnetically-Activated Implants or devices	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Any type of implanted pumps – (insulin or chemo?)	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Brain Aneurysm Clip	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Ear Implant (cochlear, other)	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Eye Implant (lens, retinal tacks?)	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Eyelid Spring or Wire	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Metallic foreign body in the eye	☐ **YES**	☐ **NO**
If yes, describe type and location?		
Any history of metal in the eye that was removed	☐ **YES**	☐ **NO**
If yes, describe date and method of removal?		
Aortic Aneurysm Repair	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		

Spinal Cord Stimulator	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Implanted coils, filters or stents	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Heart Valve Replacement or anuloplasty ring	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Penile prosthesis	☐ **YES**	☐ **NO**
If yes, do you have an implant card?		
Bullets, pellets, metal fragments or shrapnel in your body	☐ **YES**	☐ **NO**
If yes, describe type and location?		
Breast tissue expander	☐ **YES**	☐ **NO**
If yes, describe type and expected removal date?		
Any prior surgeries with surgical staples, clips, wires or rods	☐ **YES**	☐ **NO**
If yes, describe type and location?		
Other medical devises or implanted devises not listed above	☐ **YES**	☐ **NO**
If yes, describe type and location?		

I hereby affirm that all the information supplied on this questionnaire is accurate and complete. I understand that some YES answers may make it unsafe for me to work in the field of MRI and prohibit me from entering the JC MRI Technologist Certificate Program.

Applicant Signature:_____ Date:_____

MRI and CT Technologist Certificate Program
Reference Evaluation Form

_____

_____

Applicant Name

Thank you for assisting the Johnson College MRI and CT Technologist Certificate Program. We appreciate your time and effort in providing us this important information. We ask that you please indicate (**circle**) the degree to which each of the following qualities are characteristics of the candidate you are rating. Make specific comments in each category. Answer all questions using the scale below in evaluating the candidate. **Once complete, please enclose in one of your business or institution envelopes and sign your name across seal on the back of the envelope. You may give the signed, sealed envelope to the applicant to submit with their application, or you may mail this form to:**

Johnson College
Continuing Education Department
3427 N. Main Avenue
Scranton, PA 18508

Using the rubric on the next page, please give an honest appraisal of the applicant in each category listed.

_____

Recommender's Name (printed) Relationship to applicant

_____

Title Phone Number

_____

Signature Date

May we contact you? ☐ YES ☐ NO

OVERALL RECOMMENDATION:

☐ I do not recommend this student

☐ I am unsure that I can recommend this student

☐ I recommend this student with some reservations

☐ I recommend this student without reservations

☐ I strongly recommend this student

Comments:

_____
_____
_____
_____

POOR / UNSATISFACTORY Questionable skills or capability to improve	BELOW AVERAGE 25%-50% or less consistent	AVERAGE / SATISFACTORY 51%-84% or less consistent	ABOVE AVERAGE / CONSISTENTLY EXCELS 85%-94% consistent	EXCELLENT/ SUPERIOR 95%-100 consistent	Not Observed or Not Applicable
1	2	3	4	5	N

RESPONSIBILITY / DEPENDABILITY: Ability to complete assignments, work, obligations. Honors commitments.	1	2	3	4	5	N
Comments:						
INITIATIVE / MOTIVATION: Extent to which individual initiates actions, applies self, tasks, asks for assistance when needed.	1	2	3	4	5	N
Comments:						
MATURITY: Conducts self in a mature, adult manner, displaying ability to maintain composure under all circumstances.	1	2	3	4	5	N
Comments:						
ATTITUDE: Type of attitude the individual projects toward school, work, life, rules, decision making.	1	2	3	4	5	N
Comments:						
ATTENDANCE/TIME MANAGEMENT: Punctuality, regular attendance and utilization of time to accomplish tasks.	1	2	3	4	5	N
Comments:						
PROBLEM SOLVING/IDEPENDANT THINKING: Ability of the individual to identify and solve problems.	1	2	3	4	5	N
Comments:						
SELF CONTROL: Ability to deal with stressful, anxiety-producing situations appropriately.	1	2	3	4	5	N
Comments:						
COMMUNICATION: Communicates clearly concisely both verbally and written.	1	2	3	4	5	N
Comments:						
INTERPERSONAL RELATIONSHIPS: Cooperates and adapts as needed to get along with peers, co-workers, and teachers. Willing to participate with others.	1	2	3	4	5	N
Comments:						
ACCEPTANCE OF PERSONAL FEEDBACK: Ability to handle and adjust to positive or negative criticism or feedback. Is not reactionary to input or feedback.	1	2	3	4	5	N
Comments:						
CONCENTRATION/FOCUS: Ability of the individual to stay on task and finish projects or assignments within specified time limits.	1	2	3	4	5	N
Comments:						
ADAPTABILITY TO CHANGE: Ability of the individual to adapt to changes in protocols and assignments. Willingness to cover other shifts as needed.	1	2	3	4	5	N
Comments						
PATIENT CARE: Provides consistent care and attention to their patients. Is willing to assist patients with all tasks. Communicates instructions clearly.	1	2	3	4	5	N
Comments:						
PROFESSIONALISM: Conducts themselves professionally. Maintains confidentiality of patient records. Supports goals and mission of their department and institution.	1	2	3	4	5	N
Comments:						

MRI and CT Technologist Certificate Program
Reference Evaluation Form

_____

_____

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☐ I am unsure that I can recommend this student

☐ I recommend this student with some reservations

☐ I recommend this student without reservations

☐ I strongly recommend this student

Comments:

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_____
_____
_____

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