



## RADIATION THERAPY POST-ASSOCIATE DEGREE PROGRAM ADMISSION APPLICATION FORM

**DELGADO COMMUNITY COLLEGE IS AN EQUAL OPPORTUNITY FACILITY. DELGADO COMMUNITY COLLEGE DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, GENDER, AGE OR QUALIFIED DISABILITY. SUCCESSFUL ENTRY AS A STUDENT IN THE PROGRAM OF RADIATION THERAPY WILL BE BASED UPON THE MERITS OF PAST EDUCATION, EXPERIENCE, REFERENCES, RESPONSES TO THE QUESTIONS ON THE APPLICATION FORM AND POSSIBLE WRITTEN INTERVIEW.**

Use ball point pen or typewriter. Illegible or incomplete applications will be returned for revision.  
It is recommended that you *make a copy of this application for your records.*

### PERSONAL DATA:

1. Social Security Number: \_\_\_\_\_ CW ID(LOLA)# \_\_\_\_\_

2. Full Legal Name: \_\_\_\_\_  
Last First MI

3. Permanent Home Address: \_\_\_\_\_

\_\_\_\_\_ Number & Street Home Phone (Area Code and Number) Cell Phone

\_\_\_\_\_ City State Zip E-Mail Address

4. Current mailing address if different from permanent address:

\_\_\_\_\_ Number & Street

\_\_\_\_\_ City State Zip Area Code and Phone Number

5. Emergency Information:

\_\_\_\_\_ Person to Contact Relationship Area Code and Phone Number

### EDUCATIONAL DATA:

6. List all high schools, trade or vocational schools (use separate sheet if necessary)

\_\_\_\_\_ Name of School Location Grade Entered Grade Completed Graduated

7. List all colleges and universities you have attended (use separate sheet if necessary)

\_\_\_\_\_ Name Location Major Dates Attended Degree

\_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_  
Mo/Yr Mo/Yr

\_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_  
Mo/Yr Mo/Yr

\_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_  
Mo/Yr Mo/Yr

8. Are you presently enrolled in college? Yes \_\_\_\_\_ No \_\_\_\_\_ Semester \_\_\_\_\_ Institution \_\_\_\_\_

List courses you are taking this semester. \_\_\_\_\_

**EMPLOYMENT DATA:**

9. List your relevant employment experiences over the past 10 years, including military service. Add additional sheet if necessary.

1. \_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_  
Mo/Yr Mo/Yr

2. \_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_  
Mo/Yr Mo/Yr

3. \_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_  
Mo/Yr Mo/Yr

10. Are you reapplying for this program? Yes \_\_\_\_ No \_\_\_\_ . If yes, when did you last apply? \_\_\_\_\_

11. Are you a veteran of the US Military Service? Yes \_\_\_\_ No \_\_\_\_ . If YES, are you eligible for and certified by the Veterans Administration for education benefits? Yes \_\_\_\_ No \_\_\_\_ If YES, attach page to this application and give branch of service, dates entered and separated from service, rank at time of separation and type of discharge.

12. Are you a member of the National Guard or Reserve? Yes \_\_\_\_ No \_\_\_\_ . If YES, attach page to application and give branch, days and number of meetings attended each month.

13. Have you ever been suspended or dismissed from any college or university for scholastic or disciplinary reasons? Yes \_\_\_\_ No \_\_\_\_ . If YES, give name of institution, date and reason for this action. \_\_\_\_\_

14. Have you applied for admission to other Allied Health Programs at Delgado? Yes \_\_\_\_ No \_\_\_\_ . If YES, give the program name and dates.  
\_\_\_\_\_

15. Are you a U.S. Citizen? Yes \_\_\_\_ No \_\_\_\_ .

16. Optional Response: If you have a disability, describe on a separate page any special equipment, architectural modifications, or other factors which would have to be considered by you and by the School/department in planning your educational experience at Delgado Community College if you are accepted for admission.

**ALL APPLICANTS PLEASE READ CAREFULLY AND SIGN THE FOLLOWING**

Other than a minor traffic violation, have you ever been convicted of a felony? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain on additional page.

I UNDERSTAND THAT THE INFORMATION SUBMITTED ON THIS APPLICATION FOR ADMISSION TO DELGADO COMMUNITY COLLEGE'S ALLIED HEALTH PROGRAM IN MY NAME WILL BE RELIED UPON BY DELGADO COMMUNITY COLLEGE OFFICIALS TO DETERMINE MY STATUS FOR ADMISSION ELIGIBILITY. I AUTHORIZE DELGADO COMMUNITY COLLEGE OFFICIALS TO VERIFY ANY INFORMATION I HAVE PROVIDED. I FURTHER AUTHORIZE ANY AND ALL EDUCATIONAL INSTITUTIONS, GOVERNMENTAL AGENCIES, AND PRIVATE EMPLOYERS THAT I HAVE ATTENDED, WORKED FOR, OR WHO MAINTAIN RECORDS RELATED TO ME TO RELEASE SUCH INFORMATION TO DELGADO COMMUNITY COLLEGE.

I AGREE TO NOTIFY DELGADO COMMUNITY COLLEGE'S ALLIED HEALTH ADMISSIONS OFFICE OF ANY CHANGES TO THE INFORMATION PROVIDED.

I CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS COMPLETE AND CORRECT AND UNDERSTAND THAT SUBMISSION OF FALSE, INCOMPLETE, OR INCORRECT INFORMATION IS GROUNDS FOR REJECTION OF MY APPLICATION, WITHDRAWAL OF ANY ACCEPTANCE OFFER, CANCELLATION OF ENROLLMENT, OR APPROPRIATE DISCIPLINARY ACTION. I UNDERSTAND IT IS ALSO NECESSARY TO COMFORM TO THE PROGRAM'S TECHNICAL STANDARDS AND REQUIREMENTS CONCERNING A PHYSICAL EXAMINATION. **IF ACCEPTED, I AGREE TO ABIDE BY AND OBSERVE ALL PROGRAM AND AFFILIATE HOSPITAL POLICIES, RULES AND REGULATIONS, AS AMENDED FROM TIME TO TIME.**

I ALSO UNDERSTAND THAT THIS APPLICATION IS FOR THIS PROGRAM ONLY. IF I ENTER DELGADO COLLEGE, I MUST FILL OUT AND SUBMIT A DELGADO COLLEGE APPLICATION FOR ADMISSION. COMPLETION OF THIS FORM DOES NOT INDICATE THAT YOU ARE ACCEPTED INTO THE PROGRAM.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date