WEBER STATE UNIVERSITY RADIOLOGIC SCIENCES - APPLICATION FOR ADMISSION

DIAGNOSTIC MEDICAL SONOGRAPHY PROGRAM – REGIONAL

STEP 1: Apply to Weber State University online at http://weber.edu/admissions/. Once accepted to the university, you will receive a W Number in a welcome letter. This is your student ID. Current and past WSU students do not need to re-apply to WSU.

Write your W Number here: _____

STEP 2: Personal Information

Print Name: _____
Last Name First Name Middle Initial

Maiden or Other Name(s): _____

Mailing Address: _____
Number and Street City State Zip Code

Home Phone: _____ Cell Phone: _____

WSU Email: _____ (username@mail.weber.edu)

Personal Email: _____

STEP 3: Select your program. *Multiple applications must be submitted for multiple programs.*

Diagnostic Medical Sonography – Cardiac ___
Diagnostic Medical Sonography – Medical ___

STEP 4: List your proposed clinical site: _____
Are you a clinical employee of this site? Yes_____ No_____

STEP 5: Have your clinical supervisor review and complete the attached "*Characteristics of a Clinical Learning Center*." These completed forms must be submitted with your application. Applications without this information will not be accepted.

STEP 6: ☐ I am ARRT certified. (Attach a copy of your certification.)
☐ I am currently in a Radiography/X-Ray program - I will be taking the ARRT board test.
☐ I am using a previous degree as my ARRT equivalency.

STEP 7: List the most-recent colleges/universities attended/currently attending.
Official or unofficial transcripts from all institutions, including WSU, MUST be included.

NAME OF INSTITUTION	DEGREE EARNED (YES or NO)	TYPE OF DEGREE EARNED (AAS, AA, AS, BA, BS, Other) / MAJOR

STEP 8: Please list two emergency contacts:

NAME/RELATIONSHIP TO APPLICANT	DAYTIME TELEPHONE

STEP 9: Personal Essay
Provide an essay (**no more than one page**) with this application. Please include the following information:

1) Activities in which you have been involved during high school, college/university, or community in the last five years.
2) An accomplishment that has given you great satisfaction.
3) What do you enjoy doing in your leisure time?
4) Do you have any previous work or shadowing experience in a medical field? What sparked your interest in sonography?
5) Your strengths and weaknesses.
6) Any other information about yourself which you feel is pertinent to this application.

STEP 10: I DO HEREBY CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE:

X_____

Applicant Signature Date

STEP 11: Pay your ONE TIME $25 fee online. If you are submitting multiple applications, you only need to pay the fee ONCE. Be sure to include your printed receipt with your application(s).

STEP 12: Make sure to include your reference forms completed by your selected evaluators. *Letters of recommendation cannot be substituted for the included reference forms.*

STEP 13: Please submit TOGETHER, IN ONE PACKET all application materials listed:

1) Your signed application.
2) Other material requested within this application. (Essay, Certifications)
3) All college/university transcripts. Unofficial transcripts are permitted.
4) Your $25 application fee receipt.
5) Your 3 sealed reference forms.
6) The completed "Characteristics of a Clinical Learning Center" Forms

Submit application and above requested materials to:

DEPT. OF RADIOLOGIC SCIENCES
WEBER STATE UNIVERSITY
ATTN: SPECIALTY PROGRAM ADMISSIONS
3891 STADIUM WAY DEPT 3925
OGDEN UT 84408-3925

For more information, please contact the Office of Admissions Advisement at (801) 626-6057.

Weber State University does not discriminate on the basis of race, color, religion, sex, national origin, age, veteran, or handicap status. Weber State University has a policy of nondiscrimination in the admission of students.

AFFIRMTIVE ACTION INFORMATION

To enable the Radiologic Sciences Programs to make required affirmative action reports to various agencies, applicants are asked to provide the following information. Your response is optional; your decision not to provide this information will not penalize your application. You may also provide this information after you have been notified of your acceptance in the Radiologic Technology Program.

Female _____ Male _____ US Citizen: Yes_____ No _____; Specify Visa Type: _____

Ethnic Origin: White _____ Black _____ Hispanic _____ Asian/Pacific Islander _____

Native American _____ Other _____ (Specify) _____

WEBER STATE UNIVERSITY RADIOLOGIC SCIENCES - PERSONAL REFERENCE FORM

I. APPLICANT INFORMATION (to be completed by applicant)

Legal Name of Applicant _____
Last First Middle

Permanent Address _____
Number and Street City State Zip

W Number _____

TO THE APPLICANT: The Family Educational Rights and Privacy Act of 1974 and its amendments guarantee student access to educational records concerning them. Students are also permitted to waive their rights to access the recommendations. The following signed statement indicates the applicant's wish regarding this recommendation:

_____ I retain my right of access to this evaluation

_____ I voluntarily waive and relinquish my right of access to this evaluation.

II. EVALUATOR INFORMATION (to be completed by evaluator)

Name _____ Date _____

Rank or Title _____ Company_____

Evaluator Signature _____

Email _____ Phone Number_____

III. EVALUATION COMMENTS (to be completed by evaluator)

Please indicate the degree to which each quality is characteristic of the candidate you are rating. **In accordance with federal guidelines, please do not comment on: gender, race, national origin, age, religious beliefs, social/economic background, sexual orientation, political beliefs and handicaps.**

CHARACTERISTIC	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Intellectual Ability			
Initiative			
Study Habits			
Intellectual Curiosity			
Written Communication Skills			
Oral Communication Skills			
Judgment			
Team Skills			
Maturity			
Adaptability			
Dependability			
Leadership			
Personal Hygiene			
Emotional Stability			
Ethical Standards			
Interpersonal Skills			
Reaction to Criticism			
Ability to Inspire Confidence			
Awareness of Limitations			

Strongest points:

Weakest points:

☐Recommend without Reservation ☐Recommend ☐ Recommend with Reservation ☐ Do Not Recommend

PLEASE RETURN THIS FORM IN A SEALED ENVELOPE TO THE APPLICANT.

Revised: January, 2018

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CHARACTERISTICS OF A CLINICAL LEARNING CENTER

Fully completed applications must include this completed form if you are applying for acceptance and have secured a clinical scanning site outside of Northern Utah which is not affiliated with Weber State University but meets the program's clinical education requirements and is willing to provide you with scanning experience.

PROGRAM'S CLINICAL EDUCATION REQUIREMENTS

The prospective student must have a clinical affiliate which will allow them to perform scanning procedures under the supervision of a medical sonographer (medical elective) or cardiac sonographer (cardiac elective) certified by the American Registry of Diagnostic Medical Sonographers and/or a physician educated or certified in performing sonography examinations. The scanning experience for the Regional Program is a minimum of 24 hours per week for a 12-month period if the applicant has completed a radiography program or equivalent or for 24-month period if the applicant has not completed a radiography program. If this is an application to the Independent Study Program (Distance Learning) program, the applicant must be employed to gain a minimum of 35 hours per week for 48 weeks concurrent with the academic course work.

The program applicant is responsible to have this form completed and signed by this clinical site. It is strongly recommended that the program applicant discuss malpractice insurance with the potential clinical site. Malpractice Insurance is available from various organizations including the Society of Diagnostic Medical Sonography (see http://www.sdms.org).

Note: Please write clearly when completing the application form.

Date _____ 20 ____ □ Cardiac Elective □ Medical Elective

Employer / Health Care Facility Willing to Provide Clinical Education

Institution Name:
Department:
Street Address:
City, State, Zip:
Telephone Number:

Primary Supervisor: Please provide photocopy of current certification card.

Name:
ARDMS Number: _____ □ RDMS □ Abdomen □ Obstetrics-Gynecology □ Neurosonography □ Opthalmology □ Breast □ RDCS □ Adult Echocardiography □ Pediatric Echocardiography □ RVT
Telephone Number:
Email Address:

Supervising Physician and/or other Supervisory Personnel (If ARDMS certified, please include a photocopy of current certification card.)

Name:
Name:
Name:

Description of Ultrasound Equipment

Equipment Manufacturer	Model	Transducers – (Linear, Phased, Endocavitary, MultiHertz, Etc.)	Primary Utilization
Total Number of Scanning Stations _____			

Facilities Within The Institution Utilizing Sonographic Examinations

Facility	Available	Utilized
Emergency / Trauma	___ Yes ___ No	___ Yes ___ No
Intensive / Critical / Coronary Care	___ Yes ___ No	___ Yes ___ No
Neonatal Intensive Care	___ Yes ___ No	___ Yes ___ No
Surgery	___ Yes ___ No	___ Yes ___ No
General Obstetrics	___ Yes ___ No	___ Yes ___ No
High Risk Obstetrics	___ Yes ___ No	___ Yes ___ No
Angiography/ Cardiac Catheterization	___ Yes ___ No	___ Yes ___ No
Other	___ Yes ___ No	___ Yes ___ No

Annual Statistical Summary of Sonographic Procedures Performed in Department

Examination	TOTAL	Examination	TOTAL
1st Trimester Obstetrical		Adult Echocardiography	
2nd Trimester Obstetrical		Pediatric Echocardiography	
3rd Trimester Obstetrical		Fetal Echocardiography	
Gynecologic		Cardiac Other, Specify	
Abdominal			
Renal		Cardiac Other, Specify	
Prostate			
Testicular		Peripheral Vascular	
Breast		Cerebrovascular	
Thyroid		Vascular Other, Specify	
Biopsies			
Cyst Aspiration		Vascular Other, Specify	
Interventional			
Interoperative		Vascular Other, Specify	
Thoracentesis			
Medical Other, Specify		Other, Specify	
Medical Other, Specify		Other, Specify	
Medical Other, Specify		Other, Specify	

_____ **Estimated number of scanning procedures each student in this department would be allowed during a normal day.**

_____ **Estimated number of scanning procedures each sonographer/vascular technologist in this department completes during a normal day.**

My signature verifies the Characteristics of Clinical Learning Center form is correct and the applicant is currently or will have the opportunity to gain clinical experience in this department. The experience will include performing scanning procedures under the supervision of a medical sonographer (medical elective) or cardiac sonographer (cardiac elective) certified by the American Registry of Diagnostic Medical Sonographers and/or a physician educated or certified in performing sonography examinations. The scanning experience for the Regional Program is a minimum of 24 hours per week for a 12-months period if the applicant has completed a radiography program or equivalent and for the Independent Study (Distance Learning) a minimum of 35 hours per week for 48 weeks as an employee. This time frame meets the ARDMS requirements (see http://www.ardms.org).

If the student is not an employee of the facility or is not insured to practice in the facility, I have discussed with the student the need to obtain Malpractice Insurance which is available from various organizations including the Society of Diagnostic Medical Sonography (see http://www.sdms.org)

Comments:

_____

Signature of Supervising Sonographer, Vascular Technologist, or Physician

_____

Date

Questions may be directed to:

Diane M. Kawamura, PhD, RT®, RDMS, FAIUM, FSDMS
DMS Education Director, Professor
800-778-7770 extension 6841 or 801-626-6841
E-mail: dkawamura@weber.edu