



Southern Medical Corporation

School of Ultrasound

Telephone (225) 756-3327

APPLICATION FOR APPOINTMENT AS STUDENT
ULTRASOUND TECHNOLOGIST IN

CARDIAC AND VASCULAR

I. APPLICATION INSTRUCTIONS:

Applications for Admissions *must include* all college transcripts and application fee (\$100 non-refundable). As requested in the application, all required physician signatures or stamps must be included. Please type or use **BLACK** ink. Incomplete applications *cannot* be processed.

II. PERSONAL DATA:

Name: _____
First Middle Last

Home Number: (____) _____ Cell Number: (____) _____

SSN#: _____ Email Address: _____

Address: _____
Mailing Address City, State & Zip

Date of Birth _____ Sex _____

Place of Birth _____ Martial Status: _____ (Optional)
(City & State)

If Naturalized _____
(Place & Cert.#)

Notify in Case of Emergency: _____
(Name, Address, & Phone)

III. EDUCATION:

SCHOOL	NAME & LOCATION	DATES ATTENDED	DEGREE/DIPLOMA
HIGH SCHOOL			
COLLEGE OR JR COLLEGE			
OTHER			

INCLUDE COPIES OF ALL COLLEGE TRANSCRIPTS

School Activities and hobbies:

IV. EMPLOYMENT *(List last employer first)*

	NAME & ADDRESS	EMPLOYED FROM TO	POSITION	REASON FOR LEAVING
1				
2				
3				

V. CHARACTER REFERENCES:

NAME	ADDRESS	PHONE

APPLICANTS STATEMENT

The answers to the above are true and complete, to the best of my knowledge. If I accept an appointment, I agree to abide by the rules of Southern Medical Corporation, School of Ultrasound.

NOTIFICATION AND RELEASE

In connection with my application with the school, I understand that a consumer report, which may contain public records information, is being requested. This report may include the following types of information: names and dates of previous employers, credit information, etc. I further understand that such report may contain public record information concerning my credit, bankruptcy proceeding, etc. from federal, state, and other agencies, which maintain such records.

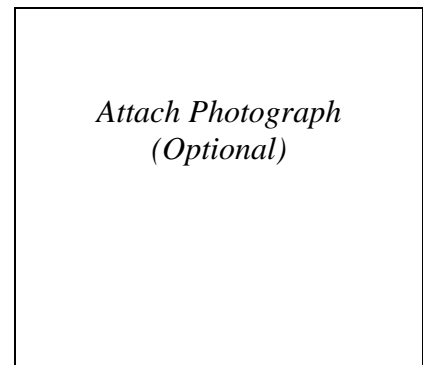
I AUTHORIZE WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED TO FURNISH THE ABOVE MENTIONED INFORMATION.

Print Name: _____ SS # _____ - _____ - _____

Print Address: _____ Date: _____

Signature: _____

Mail Completed Application to:
Southern Medical School of Ultrasound
Attn: Program Director
P O Box 84007
Baton Rouge, LA 70884



FAMILY AND PERSONAL HEALTH RECORD

Has any person in your family ever had the following. If so, please circle and give dates to the side.

Diabetes _____
Tuberculosis _____
High Blood Pressure _____
Epilepsy _____
Mental Disorder _____
Asthma _____
Chicken Pox _____
Hay Fever _____
Influenza _____
Measles _____

Mumps _____
Nephritis _____
Nervous Breakdown _____
Pleurisy _____
Pneumonia _____
Rheumatic Fever _____
Scarlet Fever _____
Small Pox _____
Typhoid _____
Whooping Cough _____

Have you had any other illnesses? Give dates.

What operations have you had? Give dates.

Describe any serious injuries. Give dates.

Please check (✓) if you are subject to the following.

- | | | |
|--|---|--|
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Impairment of vision | <input type="checkbox"/> Impairment of hearing |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Palpitation of heart | <input type="checkbox"/> Sleeplessness |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Dislocating joints | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Allergy | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Convulsion | | |

Any medical information not given elsewhere.

Do you know of any condition, which would affect your participation in any part of the training program?

What do you consider your present state of health?

Excellent Good Fair Poor

Applicant's Signature: _____ Date: _____

PHYSICIAN'S EXAMINATION REPORT (Please present to your physician pages 4 & 5)

To The Physician:

The status of the physical condition and the emotional background will serve as an important basis in the selection and admission of applicants.

Please indicate (X) condition and/or abnormalities of the following and give brief description:

____ Skin _____	____ Extremities _____
____ Eyes _____	____ Teeth _____
____ Thyroid _____	____ Vision _____
____ Nose and Throat _____	____ Blood Pressure _____
____ Heart _____	____ Posture _____
____ Lungs _____	____ Height _____
____ Abdomen _____	____ Weight _____

As a result of this examination, what remedial procedures do you recommend?

When does the applicant contemplate having them done?

What drug or treatments is the applicant receiving at this time?

Is there any other condition of note?

Has the applicant, in the past six months, required any medication other than for acute illness?

How long have you known the applicant and/or family in the medical capacity?

The following is required of all students before acceptance:

Report of PPD or Chest X-Ray

Date: _____

Result _____

Urinalysis: _____

Reaction: _____

Albumin: _____

Sp Gravity: _____

Sugar: _____

Microscope: _____

Do you recommend the applicant for admission?

Name of Physician: _____

Address of Physician: _____

Signature: _____ **Date:** _____

**Postsecondary Vocational Education
IMMUNIZATION RECORD**

Date _____ Date of Birth _____ SS# _____

Name of Student _____

Address _____

City State Zip

Immunization Record: (Mandated by Department of Health and Hospitals/Public Health, Act #17:170)

DTP/Td	OPV	MMR
1 st _____ Date	1 st _____ Date	1 st _____ Date After 1 year of age
2 nd _____ Date	2 nd _____ Date	
3 rd _____ Date	3 rd _____ Date	Booster _____ Date
Booster _____ Date	Booster _____ Date	At least one month after initial injection
Booster _____ Date	Booster _____ Date	HEPATITIS B
Booster _____ Date		_____ Date

Name of Physician _____
Signature or Stamp _____ Date _____

Address _____

Name of Physician _____
Signature or Stamp _____ Date _____

Address _____

Or
Name of Health Unit _____
Signature or Stamp _____ Date _____

Address _____