APPLICATION INSTRUCTIONS

Application Form:
Please read the application carefully and complete all pages. The application is due to the AMIT offices no later than January 9, 2017.

References:
Attached are two reference forms to be completed by persons who know you well enough to answer the questions on the form. One reference form should be completed by math or science instructors, laboratory instructors, or medical professionals holding a terminal degree (e.g. physician, dentists, veterinarians, pharmacists). The second reference form may be completed by an advisor, member of the health profession, employer, or a responsible person (not related to you). Please enter your name and the name of the reference on the form prior to giving it to the person you select.

Please note that you must sign each form authorizing release of the information by the person you select to complete the form.

If you wish to waive your right of access to the information furnished by the reference source, please sign and date the waiver clause on each reference form. Many references will require that you do this.

Please furnish each reference with a stamped envelope addressed to:

University of Cincinnati
Advanced Medical Imaging Technology Program
3202 Eden Avenue
PO Box 670394
Cincinnati, OH 45267-0394

Ask that the form be completed and mailed as soon as possible.

Resumes:
Please attach a recent resume. Be sure to include all work and volunteer experiences including dates. Be sure to include all colleges and universities attended with declared major and GPA.

Transcripts:
Official copies of transcripts from all colleges/universities you have attended are required including work done during Fall Semester 2016. Please request these as soon as possible. Transcripts may arrive separately from your application but should arrive no later than January 9, 2017. Copies should be sent to the above address.

*Degree audits will not be accepted as official transcripts.

Please note that applicants must have a minimum overall GPA of 2.8 for their application to be considered.
Background Checks:
The professional curriculum of the Advanced Medical Imaging Technology Program (to which you are now applying) will require you to provide a criminal background check as a condition of your acceptance. Background checks are generally good for 12 months so you will need to complete one each year of your professional curriculum. Clinical sites reserve the right to decline clinical positions to any student who fails to meet their expectations of conduct. Do NOT submit a background check for the purpose of this application. Arrangements will need to be made only if accepted into the professional curriculum. The program and its affiliates will not be able to refund any monies spent by the student should the student fail to satisfactorily complete a background check or fail to comply with the policies of the program and clinical affiliates regarding background checks.

Drug Screening:
Currently the professional curriculum of the Advanced Medical Imaging Technology Program (to which you are now applying), does not require drug screening. However, clinical sites have the right to change their current policies and refuse clinical positions to any student refusing or failing to meet the expected standards of a drug screen. If you are accepted into the professional curriculum, it is possible that you will need to provide evidence of a current, clean drug screen. Consequently, the program and/or its clinical affiliates reserve the right to instill a drug screening policy at any time during the professional curriculum. The program and its affiliates will not be able to refund any monies spent by the student should the student fail to satisfactorily complete any drug screening requirements or fail to comply with the policies of the program and clinical affiliates regarding drug screening.

Medical Requirements:
Students accepted into the professional curriculum will need to provide evidence of the following:
- MMR titer – must show immunities are effective
- Hepatitis B vaccine with proof of serological immunity
- Chickenpox – must demonstrate immunity
- Tetanus boosters must be current (last 10 years)
- CBC with differential – blood test
- Annual influenza inoculations
- Baseline and annual TB testing

All students are required to carry health insurance. Clinical sites reserve the right to refuse access to any student failing to comply with medical issues. Failure to provide evidence of inoculations and required testing is grounds for denying an applicant’s acceptance into the professional curriculum. Students matriculated in the professional curriculum may be dismissed if they fail to comply with inoculation and medical testing requirements.

*These Medical Requirements do not need to be completed until acceptance is finalized*

The program and its affiliates will not be able to refund any monies spent by the student should the student fail to satisfactorily complete any medical requirements or fail to comply with the policies of the program and clinical affiliates regarding medical requirements.

Professional Conduct:
All students are expected to dress and behave professionally at all times. Clinical sites reserve the right to refuse clinical positions to any student not meeting their expectations of professionalism.
**Notice of Non-Discrimination**

The University of Cincinnati does not discriminate on the basis of disability, race, color, religion, national origin, ancestry, medical condition, genetic information, marital status, sex, age, sexual orientation, veteran status or gender identity and expression in its programs and activities.

The following person has been designated to handle inquiries regarding the University’s non-discrimination policies:

Section 504, ADA, Age Act Coordinator  
340 University Hall, 51 Goodman Drive  
Cincinnati, OH 45221-0039  
Phone: (513) 556-6381; Email: HRONESTP@ucmail.uc.edu

Title IX Coordinator  
3115 Edwards 1, 45 Corry Blvd.  
Cincinnati, OH 45221  
Phone: (513) 556-3349; Email: title9@ucmail.uc.edu

For further information on notice of non-discrimination, visits http://wdcrobcolp01.ed.gov/CFAPPS/OCR/contactus.cfm for the addresses and phone numbers of the office that serves the University, or call 1-800-421-3481.

Please detach this page before submitting your application.
APPLICATION
This should be the first page of your submitted application.

Please read thoroughly the enclosed Application Instructions before completing this form.

NAME
Last Middle First

M # (UC students only) _______________________________ Date of birth __________________________

E-MAIL ADDRESS ____________________________________________

Please check the appropriate program:
☐ Bachelors Degree of AMIT – Magnetic Resonance Imaging & Nuclear Medicine (AMIT)
☐ Certificate of AMIT – Magnetic Resonance Imaging (AMIT-MRI)
☐ Certificate of AMIT – Nuclear Medicine (AMIT-NM)

MAILING ADDRESS
Street Apt. #
City State Zip Code

Telephone Number, including area code

HOME ADDRESS
(if different than mailing address) Street Apt. #
City State Zip Code

Telephone Number, including area code

EMERGENCY In case of emergency, please notify:
Name __________________ Phone __________________ Relationship __________________

Name __________________ Phone __________________ Relationship __________________
Please answer the following questions on a separate sheet of paper and attach it to this application. Be sure to include your name on the attachment. Proper grammar, spelling, and punctuation are required and will be taken into consideration regarding entry into the professional curriculum.

1. Do you have reliable transportation?

2. Estimate the number of days you have missed from school or work in the last year.

3. How do you resolve conflicts?

4. Why do you want to be a part of this program?

5. What do you expect this program will do for your future?

6. How do you manage your time?

7. What time commitment are you expecting to put into this program?

8. What subjects did you enjoy most in school and why?

9. Describe your observation experiences with medical imaging. These may come from shadowing, personal experience, work, relatives having procedures, etc. Please do not disclose any personally identifiable information regarding any patients. What did you find most interesting? What did you find least interesting?

10. What work or volunteer experiences have you enjoyed the most?

11. How will your past work or volunteer experiences help you succeed in this program?

12. What are your strong points?

13. What are your weak points?

14. Of what accomplishments in your life are you most proud?
15. Please list honors and scholarships you have received.

16. Please list all extra-curricular activities in which you participated during high school or college. Please make a note if you were in a leadership position (president, vice president, secretary, treasurer, captain, co-captain, chairperson, point person, steward, lead, etc.)

17. Which institution of higher learning did you last attend and when? What is/was your declared major?

18. What is your overall GPA from each of the institution(s) you attended (including high school)?

19. Write a brief statement describing your interest in the profession of Advanced Medical Imaging Technology and your projected, professional goals. Please limit your answer to no more than a half page of double spaced, twelve point font.

20. Are there any circumstances relevant to this application that you would like to explain?

21. Why should we accept you?
Pre-Requisite Education

On the following pages are the prerequisite courses that need to be completed before entering the professional component of the Advanced Medical Imaging Technology Program. Please indicate where the course was completed, when the course was completed, and, if not yet completed, when and where you expect to complete the course.

You may contact the College of Allied Health Sciences Academic Advising office if you have questions regarding the acceptance of transfer credits.

http://cahs.uc.edu/advising
# Advanced Medical Imaging Technology

## Prerequisite Courses – Semester Courses

<table>
<thead>
<tr>
<th>Course</th>
<th>U.C. Course #</th>
<th>Where</th>
<th>When</th>
<th>Anticipated</th>
<th>Course</th>
<th>U.C. Course #</th>
<th>Where</th>
<th>When</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Composition</td>
<td>ENGL1001</td>
<td></td>
<td></td>
<td></td>
<td>General Physics I</td>
<td>PHYS1051</td>
<td></td>
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<tr>
<td>Intermediate Composition</td>
<td>ENGL2089</td>
<td></td>
<td></td>
<td></td>
<td>General Physics II</td>
<td>PHYS1052</td>
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<tr>
<td>College Algebra</td>
<td>MATH1021</td>
<td></td>
<td></td>
<td></td>
<td>General Physics Lab I</td>
<td>PHYS1051L</td>
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<tr>
<td>Trigonometry</td>
<td>MATH1022</td>
<td></td>
<td></td>
<td></td>
<td>General Physics Lab II</td>
<td>PHYS1052L</td>
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<tr>
<td>Anatomy &amp; Physiology</td>
<td>BIOL2001c</td>
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<td></td>
<td>GOB Chemistry I OR General Chemistry I</td>
<td>CHEM1030</td>
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<tr>
<td>Anatomy &amp; Physiology</td>
<td>BIOL2002c</td>
<td></td>
<td></td>
<td></td>
<td>GOB Chemistry II OR General Chemistry II</td>
<td>CHEM1031</td>
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<tr>
<td>Pathophysiology for Health Professions</td>
<td>ALH2071</td>
<td></td>
<td></td>
<td></td>
<td>GOB Chemistry I Lab OR Gen Chem Lab I</td>
<td>CHEM1030L</td>
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<tr>
<td>Intro to Effective Speaking</td>
<td>COMM1071</td>
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<td></td>
<td>GOB Chemistry II Lab OR Gen Chem Lab II</td>
<td>CHEM1031L</td>
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<tr>
<td>Intro to Psychology</td>
<td>PSYC1001</td>
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<td></td>
<td>**Success in Allied Health I</td>
<td>HLTH1001</td>
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<tr>
<td>Health Care Ethics</td>
<td>HLSC2011</td>
<td></td>
<td></td>
<td></td>
<td>**Success in Allied Health II</td>
<td>HLTH1002</td>
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<tr>
<td>Medical Terminology</td>
<td>HLSC2012</td>
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</table>

Completion of mathematics courses up through and including MATH 1022 (Trigonometry) or the completion of MATH1044 (Applied Calc I) or higher satisfies the math requirement. **These are only required by first time freshman in CAHS.
It is reasonable to expect students to be able to fulfill all of the following duties. Students unable to fulfill all of the following duties will not be accepted into the professional curriculum of the Advanced Medical Imaging Technology Program. These are minimal standards and due to the nature of the work, special accommodations cannot be made. Do you feel as if you can do the following without assistance?

<table>
<thead>
<tr>
<th>DUTIES</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lift and assist patients using proper body mechanics.</td>
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<tr>
<td>Push and maneuver large pieces of medical equipment such as imaging equipment, computers, and portable imaging devices.</td>
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<tr>
<td>Push and maneuver patients in wheelchairs and stretchers.</td>
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<tr>
<td>See, hear, and respond quickly to patients in emergency situations.</td>
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<tr>
<td>Effectively and efficiently communicate with patients and other health care professionals in oral and written form.</td>
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<tr>
<td>Position patients and imaging equipment for medical imaging procedures.</td>
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<tr>
<td>Stand for an extended period of time and walk long distances as necessary for portable and bedside procedures.</td>
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<td>Work individually or in groups to complete assigned tasks.</td>
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<tr>
<td>Work with extremely ill or dying patients.</td>
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<td>Respond promptly and correctly to the requests of physicians, supervisors, and others in authority.</td>
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<tr>
<td>Take constructive criticism and evaluation of your work.</td>
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</table>

Also, in order to ensure the safety of each AMIT student, please complete the MRI screening questionnaire on the following page. MRI Technologists work around powerful, high-field magnets, and thus in order to work in this environment, MRI Technologists and potential AMIT/MRI students cannot have certain implants or medical devices, such as pacemakers, brain aneurysm clips, and cardiac defibrillators. Many other metallic implants are OK for working in an MR environment, however, such as hip/knee replacements, braces, dental fillings, and orthopedic screws.
MRI Screening Questionnaire

***Required to be completed by all AMIT applicants***

**MAGNETIC RESONANCE (MR) ENVIRONMENT SCREENING FORM FOR INDIVIDUALS**

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system magnet is ALWAYS on.

*NOTE: If you are a patient preparing to undergo an MR examination, you are required to fill out a different form.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Age</th>
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<tbody>
<tr>
<td>month/</td>
<td>Last Name</td>
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<td>day/year</td>
<td>First Name</td>
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<td></td>
<td>Middle Initial</td>
<td></td>
</tr>
</tbody>
</table>

Address: __________________________________________ Telephone (home) (____) __________

City: __________________________ Telephone (work) (____) __________

State: __________________________ Zip Code: __________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? □ No □ Yes
   If yes, please indicate date and type of surgery: Date _____/___/____  Type of surgery____________________

2. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)? □ No □ Yes
   If yes, please describe: ___________________________________________________________

3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? □ No □ Yes
   If yes, please describe: ___________________________________________________________

**WARNING:** Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. **Do not enter** the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

**IMPORTANT INSTRUCTIONS**

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form: ________________________________ Date _____/_____/_____

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UNIVERSITY OF CINCINNATI ADVANCED MEDICAL IMAGING TECHNOLOGY PROGRAM
3202 EDEN AVENUE, PO BOX 670394, CINCINNATI, OHIO 45267-0394
(513) 558-3515
To the Applicant:

It is necessary that we request a statement of your general health and maintain such in our records. Please print your name in the appropriate space on the form below. Detach the form and have it signed by your physician, physician assistant, nurse practitioner, or other qualified healthcare provider. Return the form along with your application materials.

Note: This is not a request for a physical, only a statement concerning your general health.

-------------------------------------------------------

University of Cincinnati
Advanced Medical Imaging Technology Program

Applicant Name (please print)

I hereby authorize the individual named below to provide the requested information.

Applicant Signature

To the best of my knowledge, the above named individual is in good physical and mental health and should be able to carry out the activities associated with obtaining diagnostic medical images in Magnetic Resonance Imaging, Nuclear Medicine Technology, and/or Computed Tomography.

Printed Name (Physician, Physician Assistant, Nurse Practitioner, or other qualified healthcare provider)

Signature

Date

Return to applicant or mail to:
University of Cincinnati
Advanced Medical Imaging Technology Program
PO Box 670394
Cincinnati, OH 45267-0394
I pledge that the information on this entire application is correct and without purposeful omissions.

__________________________  ______________________________  ______________________________
Signature of Applicant      Date

Return application, including physician statement to:

University of Cincinnati  
Advanced Medical Imaging Technology Program  
PO Box 670394  
Cincinnati, OH 45267-0394

The application can also be returned in person to:

Advanced Medical Imaging Technology Program  
Room 215 French East  
College of Allied Health Sciences

The deadline for submission is January 9, 2017 at 8:00 am. Late applications will NOT be considered.
# REFERENCE FORM

**To the Applicant:**
Place your name in the space provided and sign the waiver if you agree to waive your right to read this appraisal. Give or mail it to the person named below and request that it be forwarded to the address given on the second page of this form.

**Applicant Name:**

**Evaluator Name:**

**Phone:**

I hereby authorize the above named individual to provide the requested information.

**Applicant Signature:**

**Date:**

Under the provisions of the Family Educational Rights and Privacy Act of 1974, this applicant, if admitted and enrolled, will have access to the information provided unless he/she waives such access.

---

**To the Evaluator:**
On the basis of the following personal qualities, please indicate your appraisal of the applicant on a scale of 1 to 5, as follows:

- **5** - Excellent
- **4** - Above Average
- **3** - Average
- **2** - Below Average
- **1** - Unsatisfactory

If you are unable to evaluate any trait, please so indicate by placing an “X” in the last column.

<table>
<thead>
<tr>
<th>Trait</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>X</th>
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</thead>
<tbody>
<tr>
<td>Judgment and Problem-Solving</td>
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<tr>
<td>Manual Dexterity</td>
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<td>Personality</td>
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<tr>
<td>Poise</td>
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<td>X</td>
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<td>Communication Skills</td>
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<td>Initiative</td>
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<td>Adherence to Established Policies &amp; Regulations</td>
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<td>Flexibility</td>
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<td>Dependability</td>
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<td>Industry</td>
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<td>Interpersonal Relation Skills</td>
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<tr>
<td>Maturity</td>
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</tbody>
</table>

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How long and in what capacity have you known the applicant?

Please write any additional comments or information that might assist us in our evaluation of this applicant.

Signature

Title

Institution or Address

Date

Do not return this form to the applicant. Please mail directly to:

University of Cincinnati
Advanced Medical Imaging Technology Program
PO Box 670394
Cincinnati, OH 45267-0394
REFERENCE FORM

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Place your name in the space provided and sign the waiver if you agree to waive your right to read this appraisal. Give or mail it to the person named below and request that it be forwarded to the address given on the second page of this form.

Applicant Name: ________________________________
Evaluator Name: ________________________________
Phone: ________________________________

I hereby authorize the above named individual to provide the requested information.

Applicant Signature: ________________________________
Date: ________________________________

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<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgment and Problem-Solving (responsible, critical)</td>
<td></td>
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<tr>
<td>Manual Dexterity (agile, coordinated)</td>
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<tr>
<td>Personality (pleasant)</td>
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<tr>
<td>Poise (self-confident, responds well to unfamiliar demands)</td>
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<tr>
<td>Communication Skills (articulate, clear, grammatical, responsive)</td>
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<tr>
<td>Initiative (motivation, commitment, desire to succeed)</td>
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<tr>
<td>Adherence to Established Policies &amp; Regulations</td>
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<tr>
<td>Flexibility (responds or conforms to changes or new situations)</td>
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<tr>
<td>Dependability (responsible)</td>
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<tr>
<td>Industry (diligent, prompt, persistent, organized)</td>
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<tr>
<td>Interpersonal Relation Skills (courteous, cooperative, tactful, able to motivate, persuasive)</td>
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<tr>
<td>Maturity (stability, self-disciplined, receptive to criticism)</td>
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</tbody>
</table>

I HEREBY WAIVE MY RIGHT OF ACCESS TO THE INFORMATION RECORDED ON THIS FORM.

Signature of Applicant ________________________________
Date: ________________________________

______________________________________
How long and in what capacity have you known the applicant?

Please write any additional comments or information that might assist us in our evaluation of this applicant.

Signature

Title

Institution or Address

Date

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Cincinnati, OH 45267-0394