



**EDUCATION:**

Please list ALL secondary and post-secondary academic institutions attended. If needed, please attach an additional page.

Name & Location of School	Years Attended		Year Graduated	Degree/ Diploma
	From:	To:		
COLLEGE/ UNIVERSITY				
COLLEGE/ UNIVERSITY				
COLLEGE/ UNIVERSITY				
OTHER				

**EMPLOYMENT HISTORY:**

<u>Employer</u>	<u>Position Held</u>	<u>Dates Employed</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any previous hospital experience? \_\_\_\_\_ If yes, where? \_\_\_\_\_

What capacity? \_\_\_\_\_ When? \_\_\_\_\_

**IN CASE OF AN EMERGENCY, PLEASE NOTIFY:**

NAME \_\_\_\_\_  
Last First

ADDRESS \_\_\_\_\_  
Street City State Zip

TELEPHONE ( ) \_\_\_\_\_

**REFERENCES:**

Please include previous or current employers, teachers, TA's; do not include friends or relatives.

<u>Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I acknowledge that the information I have supplied in this application is correct and understand that any falsification of information on this form may be cause for rejection as an applicant. I understand that this application is not legally binding on me in any way, that I am not obligated to enroll in the clinical program to which I may be assigned and that after enrollment as a student I have the right to withdraw voluntarily from the program for personal reasons.

I also understand that, if accepted, and enrolled as a student, I shall be subject to dismissal from the program for poor scholastic and/or technical performance, criminal acts or proved charges of unprofessional conduct. I further understand that acceptance by the clinical affiliate site will require me to obey all regulations affecting personnel within the hospital.

I have read the Program Bulletin and understand it. Any questions that I have concerning the Program Bulletin and how they apply to me have been answered by the UWHC Program Director and/or the Clinical Education Coordinator to my satisfaction. It is my belief that I can satisfy each of the health requirements and physical requirements listed in the Program Bulletin based on my existing skills and abilities, or through the use of corrective devices.

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Signature of Applicant

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Date

- The completed application form.
- Two completed reference forms.

**SUBMIT THE ABOVE FORMS BY DECEMBER 1<sup>ST</sup> TO:**

Cindy Brown, Clinical Associate Professor  
UW-Milwaukee College of Health Sciences  
Enderis Hall, Room 463  
2400 E. Hartford Ave.  
PO Box 413  
Milwaukee, WI 53201  
or  
Fax: (414) 229-2619

# STUDENT APPLICATION CHECKLIST

**Attention Applicant :** *please detach this page from your application to refer to during the rest of your application process to UWHC School of DMS.*

**SUBMIT THE FOLLOWING APPLICATION MATERIALS DIRECTLY TO  
THE UWHC SCHOOL OF DMS AT THE ADDRESS LISTED BELOW  
BY JANUARY 31<sup>ST</sup>:**

- Official transcripts of all college credits – *Official transcripts must be mailed to the UWHC School of DMS from the school that issued them.***
- Documented 100 hours of patient care form (or proof that patient care hours are in-progress).\***
- Copy of current CPR certification card (or proof that CPR course is in-progress).**
- Copy of Radiologic Technologist Registry card or Certified Nursing Assistant card (or proof that CNA course is in-progress).\***

\*See “Application Requirements” in DMS Program Bulletin.

Bridgett Willey, Program Director  
UWHC School of Diagnostic Medical Sonography  
2870 University Avenue, Suite 108  
Madison, WI 53705  
or  
Fax: (608)263-9208