



**A. Personal Data (continued)**

2. Social Security Number XXX – XX - \_\_\_\_\_
3. Contact : Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_
4. Cell Phone ( ) \_\_\_\_\_
5. E-mail: \_\_\_\_\_

**B. EDUCATION**

List colleges or schools attended with most recent first: If transcripts are under another name please indicate \_\_\_\_\_.

College/School & Location	Years Attended		Graduate		Degree and/or Diploma
	From	To	Y	N	

List below all professional certifications and/or licenses (e.g., RN, RT, CNMT, RDMS, etc.) with effective dates :

License/Certification	Number	Effective Date

**C. Employment**

Please list all employers for the past five (5) years beginning from most recent:

Employer	Address	Position	Dates of Employment	Phone #

D. Describe any volunteer work that you may have done (may use additional page if necessary)

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**E. STATEMENT OF INTENT**

On a separate sheet of paper, in 200 words or less, state why you chose a career in the health care profession and outline your specific career goals in medical imaging.

**F. REFERENCE FORM**

**All applicants to the program are required to submit at least two references in sealed envelopes with a signature across the seal. Use the form provided below.**

Applicants must request a reference from a professor or instructor of one of your prerequisite science courses and a letter from your current employer.

Applicants certified in a clinical health care specialty must request a reference from the Program Director of your specialty training course and a letter from your current employer.

**G. SHADOW DAY FORM**

A shadow day form is required for the Radiography Program. A documented shadow experience is highly recommended for the Nuclear Medicine Technology and Diagnostic Medical Sonography Programs.

The forms for the Radiography, Nuclear Medicine Technology, and Diagnostic Medical Sonography Programs can be found below. Please note that you only need to submit the Shadow Form(s) for the Programs you applying to. You do not need to shadow in all modalities.

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I hereby certify that the facts set forth in the above application are true and complete to the best of my knowledge. I understand that, if accepted, falsified statements on this application shall be considered sufficient cause for dismissal from the program.

I also understand that admission into the Program of Medical Imaging constitutes adherence to all hospital and school policies and regulations.

If selected for the Program of Medical Imaging, I agree to have a medical examination at The Johns Hopkins Hospital during admission / enrollment.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

In the space below, please tell us how you heard about The Johns Hopkins Hospital Schools of Medical Imaging. Thank You!

The Johns Hopkins Medical Imaging Schools admits students of any race, color, sex, disability, and national or ethnic origin to all of the rights, privileges, program benefits and activities generally accorded or made available to students at the Medical Imaging School.



**Please rate the applicant using the following scale :**

	Outstanding Top 5%	Above Average Top 25%	Average Top 50%	Below Average	No opportunity to observe
Ability to avoid and resolve conflict					
Ability to complete a task					
Ability to work with others					
Academic ability					
Accepts constructive criticism and makes attempt to improve					
Attendance					
Attention to detail					
Coping skills in a stressful environment					
Judgment and maturity					
Leadership capabilities					
Morale builder versus morale depressor					
Motivation					
Oral communication					
Problem solving ability					
Quality of written expression					

Please add any remarks that you feel the Admissions Committee may find helpful. You may attach these on a separate paper if you choose.

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**What is your recommendation for admission to the Schools of Medical Imaging?**

- Strongest recommendation
- Recommendation with confidence
- Recommended
- Recommended with reservation
- Not recommended

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Signature of Referrer

Date

The Johns Hopkins Hospital Schools of Medical Imaging sincerely appreciates your time in filling out the recommendation form. Your recommendation will be strongly considered in the selection process. Thank you.



**The Johns Hopkins Hospital  
Schools of Medical Imaging  
Program in Radiography  
Shadowing Agenda**

**General Directions:** You may shadow at a Hospital of your choice. Please contact Mr. Al Traylor at 410-528-8234 to schedule a shadow day at JHH. If visiting hospitals other than JHH, please be sure you observe in all the areas listed below. Include the name of the department where observations were taken place. Please complete the areas listed below, insuring that all goals are completed and that you have an understanding of some of the examinations we perform. A minimum of four hours shadowing is required. It is only required that you visit Diagnostic Radiography; it is not necessary to visit CT, MRI, etc.

Name of hospital where shadowing was completed: \_\_\_\_\_

Signature of supervising technologist: \_\_\_\_\_

Prospective Student: \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_ to \_\_\_\_\_

<b>Fluoroscopy</b>	<b>Goals</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Observe fluoroscopic examinations. Be able to describe these examinations.</li> <li><input type="checkbox"/> Observe basic anatomy on images.</li> <li><input type="checkbox"/> Understand how the image is obtained.</li> <li><input type="checkbox"/> Observe and name basic components of imaging equipment.</li> <li><input type="checkbox"/> Observe technologist interaction with radiologist and patient during fluoroscopy studies.</li> </ul>
<b>General or Emergency Room</b>	<b>Goals</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Observe several diagnostic examinations. Be able to describe these examinations.</li> <li><input type="checkbox"/> Observe basic anatomy on images.</li> <li><input type="checkbox"/> Understand how the image is obtained.</li> <li><input type="checkbox"/> Observe technologist setting technical factors, patient interaction, etc.</li> <li><input type="checkbox"/> Observe basic components of imaging equipment. Be able to describe the equipment.</li> <li><input type="checkbox"/> Be able to describe the role of the radiographer.</li> </ul>
<b>Mobile/Portable</b>	<b>Goals</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Observe mobile examinations.</li> <li><input type="checkbox"/> Observe basic components of imaging equipment.</li> <li><input type="checkbox"/> Understand patient needs encountered during mobile radiographic procedures.</li> <li><input type="checkbox"/> Be able to describe the role of the radiographer</li> </ul>

# The Johns Hopkins School of Medical Imaging Nuclear Medicine Technology Program

## SHADOW EXPERIENCE FORM

**General Directions:** You may shadow at a Hospital of your choice. Please contact the Program Director, at 410-528-8299 to schedule a shadow day at The Johns Hopkins Hospital. Be sure to fill out the form below accurately. A minimum of four hours of shadowing is recommended. It is not necessary to visit Radiography, CT, MRI, or Ultrasound.

Student Name \_\_\_\_\_

Clinical Facility Name \_\_\_\_\_

Clinical Facility Contact  
Information \_\_\_\_\_

Date(s) of Experience \_\_\_\_\_

Clocked Hours of Experience \_\_\_\_\_

Name of Staff Technologist \_\_\_\_\_

Signature of Staff  
Technologist \_\_\_\_\_

Please list some of the procedures you had the opportunity to observe:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

\*Please include this form with your application for admission. If you complete a shadow experience after you submit your application, you may mail it separately to: The Schools of

Medical Imaging

Attn: Jay K. Rhine, BS, CNMT

8 Market Place, Suite 600

Baltimore, MD 21202

or Fax to # 410-528-8308

**The Johns Hopkins School of Medical Imaging  
Diagnostic Medical Sonography (Ultrasound) Program**

**SHADOW EXPERIENCE FORM**

**General Directions:** You may shadow at a **Hospital** of your choice. Please contact Mr. Justin Stevens, RDMS, RVT, at 410-528-8209 to schedule a shadow day at Johns Hopkins Hospital. Be sure to fill out the form below accurately. A minimum of three hours of shadowing is recommended. It is not necessary to visit Radiography, CT, MRI, or Nuclear Medicine.

Student Name \_\_\_\_\_

Clinical Facility Name \_\_\_\_\_

Clinical Facility Contact  
Information \_\_\_\_\_

Date(s) of Experience \_\_\_\_\_ Clocked Hours of  
Experience \_\_\_\_\_

Name of Sonographer \_\_\_\_\_

Signature of Sonographer \_\_\_\_\_

Please list some of the procedures you had the opportunity to observe:

Examples: Abdomen, OB/GYN, Small Parts, Vascular exams. Interventional scans such as intra-operative O.R. scans and biopsy-guidance. Pediatric and Portable exams may be observed as well.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

*\*Please include this form with your application for admission. If you complete a shadow experience after you submit your application, you may mail it separately to:*

**The Schools of Medical Imaging  
Attn: Mrs. Carol Iversen, DMS Program Director  
8 Market Place, Suite 600  
Baltimore, MD 21202  
or  
Fax to # 410-528-8308**