

REFERENCES

Give the name and address of two mature persons, not relatives, who know you personally and can give information about your work ethic, character and academic aptitude.

Name	Address	City, State	Position or Title

I certify that answers given herein are true and complete to the best of my knowledge. I understand that intentional false statements made on this application or incomplete information will be used as a base for denying admission or dismissal from the program if discovered. I also understand that further investigation regarding my past criminal history records may be undertaken based on my responses to the above questions and that information regarding a formal background check will be provided to me in the event that further investigation is found to be necessary.

Signature

Date

CHECKLIST

Application	
High School Transcript	
College Transcript	
Recommendation # 1	
Recommendation # 2	
Technical Standards Form	
Job Shadowing & Health Care Experience Form	
Self Disclosure Form	

St. Cloud Hospital School of Diagnostic Imaging goes not discriminate because of race, color, religion, sex, marital status, sexual orientation, national origin, age, or status with regard to public assistance or disability.