Marshfield Clinic
Health System

School of Radiography – 2020

Admission Application

*This application will not be considered complete unless all requested information below is provided, and all application requirements are met and received. Refer to the **Application Requirements** and **Application Checklist** for required components. Applications are accepted August 1 – February 30, with first consideration given to those completed and submitted by December 1. Information is not retained for repeat applications. All requirements must be resubmitted each applying year.*

There are two methods of submission:

- **Submit Admission Application electronically:**
  Email: schoolofradiology@marshfieldclinic.org
- **Submit Admission Application via postal service:**
  Marshfield Clinic Health System Division of Education
  School of Radiography Program Director, ML9
  1000 North Oak Avenue, Marshfield, WI 54449

Personal information

Name (PRINT)		
Street address		
City	State	ZIP code
Phone numbers: Cell	Home	
E-mail address		

Application fee

Application fee is $25. Check or money order can be sent by mail. Credit card payment may be made by calling Student Programs at 715-387-9251.

ACT Score Report

Official ACT Score Report must be submitted directly from Testing Site or College Affiliate by February 30. Score reports will not be accepted from applicant.

ACT date completed ____________________

ACT composite score ____________________

ACT math score ____________________

ACT science score ____________________

Observation/Shadowing

Applicants must complete a minimum of 12 hours observation/shadowing in a Diagnostic Radiology department. **Students must submit Observation Verification forms by the application deadline.** Applications will not be considered for applicants not completing the minimum observation hours.

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Observation/Shadowing *(continued)*

Shadowing experience #1

Institution shadowed	Department shadowed		Date shadowed
Address		Hours	Minutes

Shadowing experience #2

Institution shadowed	Department shadowed		Date shadowed
Address		Hours	Minutes

Shadowing experience #3

Institution shadowed	Department shadowed		Date shadowed
Address		Hours	Minutes

Shadowing experience #4

Institution shadowed	Department shadowed		Date shadowed
Address		Hours	Minutes

Education

List all educational institutions that you have attended, starting with the most recent. All official **high school and college** transcripts must be sent to Marshfield Clinic Health System, School of Radiography **by the application deadline.** Electronic submission of official transcripts may be emailed to schoolofradiology@marshfieldclinic.org. **No unofficial transcripts will be accepted. Applications without official transcripts will not be considered.**

School name

Location

Dates attended: From ____________________ to ____________________ | Graduated: ☐ Yes ☐ No

School name

Location

Dates attended: From ____________________ to ____________________ | Graduated: ☐ Yes ☐ No

School name

Location

Dates attended: From ____________________ to ____________________ | Graduated: ☐ Yes ☐ No

High school

Location

Dates attended: From ____________________ to ____________________ | Graduated: ☐ Yes ☐ No

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References

A minimum of three references (non-related) are required. Each person listed must complete an Applicant Reference Request and mail or email directly to Marshfield Clinic Health System, School of Radiography by the application deadline. Applicant Reference Requests sent to the program by the applicant will not be accepted. Students from affiliate universities must include a minimum of one professor as a reference. **Applications without returned Reference Requests will not be considered.**

Reference name	
Relationship	Length of relationship
Address	Phone
Email address	

Reference name	
Relationship	Length of relationship
Address	Phone
Email address	

Reference name	
Relationship	Length of relationship
Address	Phone
Email address	

Signature

The information I have provided on this application is true and complete to the best of my knowledge.
I understand that failure to submit required documents will disqualify my application.

Signature ____ Date (m/d/y) ______ /______ /______

It is the policy of Marshfield Clinic Health System to consider all applicants for admission without regard to age, race, religion, creed, color, handicap, marital status, sex, national origin, ancestry, political affiliation, sexual orientation, military reserve status, or any other unlawful bias.

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