Southwestern Michigan College MRI/EEG/Radiography/Cardiovascular Technician Program Application

Application Checklist

Complete the Full Checklist BEFORE submitting.

Forms to Be Signed

_____Application to Begin Program

_____ Health Record – Physician's Form

_____ Health Record – Applicant's Form

_____ Criminal Background Check Consent Form

Other Required Documentation

_____High School Transcript/GED **Must be on file with Records Dept. prior to application submission* ** If you are a current High School student please email or call the nursing advisor.

_____College Transcripts (if applicable) **Must be on file with Records Dept. prior to application submission* Please list attended colleges below

- _____
- _____
- _____

_____Copy of Driver's License

_____Proof of U.S. citizenship, legal permanent residence, or valid non-immigrant status that permits study in the United States or Valid DACA Approval.

*Acceptable documentation:

- **U.S. Citizenship** - birth certificate, passport, certificate of naturalization
- **Legal Permanent Residence** - permanent resident card (green card)
- **Non-Immigrant Status** - I-20 Certificate of Eligibility for F-1 students or visa stamp + I-94 record or I-797 Approval Notice for Change of Status + I-94 record
- **DACA** - I-797 Approval notice for consideration of Deferred Action of Childhood Arrivals.

Other Requirements

_____ SMC Student ID picture taken. This may be done at the Dowagiac Campus in the Student Activity Center or at the Niles Campus Main Office

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Complete and return to the Nursing and Health Services Department. Electronic signatures are not accepted.

NAME

Last: _____ First: _____ Student ID#_____

LOCAL ADDRESS

Street: _____

City: _____State: _____Zip: _____

PHONE: Home (_) _____Work (_) _____

SMC EMAIL: _____@swmich.edu NON-SMC EMAIL: _____

For which program are you applying for? (Check one)

MRI _____ (Summer Start)
EEG _____ (Fall Start Only)
Radiography_____ (Fall Start)
Cardiovascular Tech _____ (Fall Start)

Please Initial the below statement: _____

**NOTE: Prerequisites may only be repeated once to be considered for admittance to the the MRI/EEG/Radiography/Cardiovascular Technician program

Signature:_____ Date:_____

Southwestern Michigan College
Criminal Record Check Consent Form

As a health careers student at Southwestern Michigan College, I understand that it is the policy of the institution to secure criminal conviction history information as part of the screening process for students using the information provided below. **List all states that you have worked or lived in for the past seven years.** NOTE: **A copy of your current driver's license must be submitted with this form.**
58900 Cherry Grove Road, Dowagiac, Michigan 49047 Phone: 269-782-1236 Fax: 269-782-1239

I understand that the Central Records Division of the Michigan State Police, Lansing, Michigan, requires the above information. I authorize Southwestern Michigan College to utilize the above information for the purpose of obtaining a conviction only crime file search. I understand that if it is discovered that I have a criminal record, it will prohibit my admission to a health careers program.

Date: _____ Applicant Print Name: _____

Applicant's Signature: _____

Southwestern Michigan College
Health Record/ Physician's Form

TO THE PHYSICIAN: The applicant has been asked to complete the history on the attached copy. Please review for accuracy. Using the following form please make the necessary examinations. This information will be used in the best interest of the applicant and patient safety. This applicant is being considered for a health occupation; therefore, we are concerned about physical stamina. 58900 Cherry Grove Rd, Dowagiac, MI 49047

Applicant's Name: _____

Ht_____ Wt_____ BP_____ P_____ R_____ T_____

Check Each Item

	Normal	Abnormal	Nature of Abnormality
Skin			
Head/ Neck/ Thyroid			
Eyes/Vision			
Ears/Hearing			
Nose/Sinuses/Mouth			
Throat/Nodes			
Chest/Breasts			
Lungs			
Heart			
Abdomen			
Extremities/Joints			
Vascular			
Neuro/Reflexes			
Mental Status			

Is this applicant subject to any physical limitations? No_____ Yes_____

Explain, if yes_____

Additional comments regarding the applicant's physical and/or mental health?

_____

Physician's Signature_____ Date_____

Address_____

Southwestern Michigan College
Health Record/ Applicant's Form

INSTRUCTIONS TO THE APPLICANT: This form must be completed, signed and returned to The Nursing Office. All information is confidential and should be as complete as possible. This information will be used in the best interest of the applicant and patient safety. 58900 Cherry Grove Rd, Dowagiac, MI 49047

Please PRINT IN INK or TYPE. You should complete this form. Your physician should complete the Physician's form. Please make sure that you and your physician sign in the proper places.

PART ONE—TO BE COMPLETED BY THE APPLICANT DATE_____

Name _____ Sex (M) (F) DOB_____

Street _____ Student ID # _____

City _____ State _____ ZIP _____

Current Phone number (hm) _____ (wk) _____

Current Medications _____

Current conditions under MD's Care _____

Sensitivities or Allergies _____

Physical Impairments _____

Do you have a lifting weight restriction-if yes, please explain

_____

HISTORY Have you had: (check each item)

	No	Yes	If Yes, Explain
Tuberculosis			
Diabetes			
Epilepsy			
Cancer			
Asthma			
Heart Disease			
High Blood Pressure			
Eye or Ear Problems			
Shortness of Breath			
Kidney Disease			
Fainting or Dizzy Spells			
Color Blindness			
Contact Lenses			
Severe headaches			
Anxiety Reactions			

NEXT PAGE

PAGE 2 of Health Record/ Applications Form

PRINT name of physician who will perform your examination:

Name _____

Street _____

City _____ State _____ ZIP _____

Phone _____

To the best of my knowledge, the above information is correct. I understand that misinformation may result in dismissal.

Applicant's Signature _____

Date _____

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These items will be required after being accepted into the MRI/EEG/Radiography/Cardiovascular Technician Program and will be explained in further detail at orientation.

Health Requirements

- TB Test (Mantoux-1yr; Skin or QuantiFERON Gold Blood test; Chest X-rays are no longer accepted unless positive skin test).

Immunization Records

- MMR (Titers OR 2 vaccine series)
- TdaP (No more than 10 Years old)
- Hepatitis B (Titers or Full vaccine series)
- Varicella Zoster Vaccine (Titers or Vaccine Series)
- Current season flu vaccine (yearly)

Highly Recommended

- Covid 19 Vaccination Series or Exemption Form

Additional Requirements

- CPR Certification