University of Findlay
Diagnostic Medical Sonography

Diagnostic Medical Sonography Programs
Application for Admission

Instructions: Please type or print in ink. Fill form out completely.

Date _____ UF ID # _____

1. This application is for the term beginning: January of 20 ____ (yy) or August of 20 ____ (yy)

2. _____
Last (Family) Name First Name Middle Name Maiden Name

3. Mailing Address: _____
Street City/State/Zip

4. E-Mail Address: _____

5. Telephone: _____
(Area Code) Daytime (Area Code) Evening

6. Gender: Male Female

7. Citizenship: U.S. Permanent Resident F-1 Country of Citizenship: _____

8. Date of Birth: _____ 10. Place of Birth: _____
Month/Day/Year City, State Country

9. Last High School Attended: _____ City, State _____

Date of Graduation: _____

10. Previous academic work: (List all academic work beyond high school)

Name of Institution	City and State	Major (s)	Degree and Date

11. Please circle the degree that you are seeking: Associate Degree Bachelor Degree Certificate

12. Please circle **one** program that you are applying for: General Sonography Vascular Sonography Echocardiography

13. Student Type (Please circle one): First Time Freshman Transfer Re-Admission College Credit Plus

PLEASE READ CAREFULLY:
I certify that I have read and understand the contents of this application. I certify the information on this application is accurate and complete, and any falsification or omission may cause my acceptance to be terminated or my application rejected. If accepted, I agree to observe all rules and regulations of the Diagnostic Medical Sonography Programs and The University of Findlay during the program.

Signature: _____ Date: _____

The University of Findlay is an equal opportunity institution and welcomes applications from any race, color, sex, age, religion, creed, national origin, or handicap.

FINDLAY

THE UNIVERSITY OF FINDLAY

Diagnostic Medical Sonography Programs

1000 North Main Street
Findlay, OH 45840
419-434-5886

Application Instructions:

1. Complete ***this application and the Patient Confidentiality Agreement*** and submit it to:

   Diagnostic Medical Sonography Program Office at the address given above. A **NON – REFUNDABLE** $ 50.00 application fee (check or money order made payable to The University of Findlay – no cash please) must accompany the application in order for it to be processed.

2. Applicants receiving their post-secondary education outside of The United States must have their credentials evaluated by an acceptable credentials evaluation service or the University to show U.S. equivalency. Official copies of high school, college, and technical training transcripts must be forwarded to the University. When applicable, verification of registry status and/or a credentials evaluation must be on file with the University for review by the Admissions Committee.

3. **When all materials (forms, transcripts and application) have been received, your application will be reviewed for admission and you will be notified of the Admissions Committee's decision.**

University of Findlay
Diagnostic Medical Sonography

Patient Confidentiality Agreement

This form must be signed and returned to the Diagnostic Medical Sonography Program Office prior to the student completing the required hours of observation.

Under no circumstances, will the student be permitted to complete any hours of observation without receipt of this form. Should a student complete the hours of observation without completion and receipt of this form in the program office, the students' application will not be considered for any Diagnostic Medical Sonography Program.

Rationale:
A major responsibility of a sonographer is to maintain the privacy and confidentiality of the patient. This is a fundamental element in professional and ethical conduct. As a perspective student observing during the application process, you have access to sensitive and confidential information about the patients, visitors and staff at the site. Any information obtained while performing your observation hours must be kept strictly confidential. This information is not to be discussed with anyone other than those individuals associated with the care of the patient.

The clinical site has given you permission to observe in their department because you are an applicant for Diagnostic Medical Sonography Programs at The University of Findlay. The sonography department and The University of Findlay expects that you will conduct yourself in an ethical manner and hold all private information confidential.

I, _____ understand and agree that during the performance of my required hours of observation for application to the Diagnostic Medical Sonography Programs, any patient information I obtain at the clinical site will be kept strictly confidential. I also understand that violation of this policy will result in ineligibility for admission to the Diagnostic Medical Sonography Programs and may result in legal action under the Health Information Portability and Accountability Act (HIPAA).

I understand that the host facility may ask me to discontinue observation at any time they believe my actions are inappropriate.

Signature of applicant is required.

Signature**:** _____ Date _____

Printed Name**:** _____