SOVAH
School of Health Professions

APPLICATION FOR ADMISSION

Diagnostic Medical Sonography

ADMISSION CRITERIA

Early Application is STRONGLY recommended! For the class commencing 1/4/22, the application MUST be <u>received</u> no later than 11/1/21. Do NOT mail the final week before it is due – Hand deliver the application if timely arrival is not assured.

1.Completed applications must contain the following:

- **A. Completed application form with the $50 non-refundable fee.**
  <u>Please make all checks payable to: SOVAH School of Health Professions</u>
- **B. An essay. (guidelines include below)**
- **C. 3 letters of reference. (forms included below)**
- **D. Official college transcripts are required (sealed envelopes).**

(We ask that ALL information be sent in one packet to reduce processing time and errors.)

2. All information will be kept strictly confidential.

3. Applicants are selected in accordance with nondiscriminatory policies.

4. Permission is granted to consult previous educators, employers, and agencies.

5. SOVAH School of Health Professions will perform criminal background checks on all applicants; any false statements will be grounds for non-acceptance or dismissal.

6. Minimum APPLICATION pre-requisite educational requirements:

- ***A.*** **Applicants must be graduates of an accredited Radiologic Technology Program recognized by the ARRT or graduate of an accredited Allied Health Program (Nursing, Respiratory Therapy, etc.) prior to beginning the Sonography Program.**
- ***B.*** **General college physics course**

7. The following classes are not required but strongly encouraged. Note that these classes will likely be required for future program acceptance.

- √ **Math 155 or higher**
- √ **Medical Terminology I**
- √ **Human Anatomy & Physiology II**

8. Acceptance of students is a two-part process based upon results of:
Part 1. Completed application score and
Part 2. Personal interview score.
Each candidate's application and transcripts will be reviewed with a score being obtained from academic grades in math, science, and other relative courses. (Advanced/college prep courses will carry more weight than standard course work.) Based on these scores the most qualified individuals will be granted a personal interview. The interview scores will be added to the application score to make our final decisions.

9. Acceptance into the SOVAH School of Health Professions' Diagnostic Medical Sonography Program is also contingent upon potential students passing a pre-enrollment drug screening and physical examination. Results of these tests are confidential and are maintained by the institution.

10. Technical standards: Due to the nature of this profession and considering the safety of our patients and our students, applicants must be able to meet all of the following technical standards in order to be considered for enrollment.

A. **Sufficient corrected eyesight to observe patients, manipulate equipment and evaluate radiographic quality.**
B. **Sufficient corrected hearing to assess patient needs and communicate verbally with other healthcare providers.**
C. **Sufficient verbal and written skills to communicate needs promptly and effectively in English.**
D. **Sufficient gross and fine motor coordination to respond promptly, manipulate equipment, lift a minimum of 30 pounds and ensure patient safety.**
E. **Intellectual and emotional functions needed to exercise independent judgment and discretion in the safe technical performance of medical imaging procedures.**

SOVAH
School of Health Professions

APPLICATION FOR ADMISSION

Diagnostic Medical Sonography

APPLICATION DUE BY October 9, 2020

- **This application must be accompanied by a *non-refundable $50 application fee (Checks or money orders only)*.**
  - **Please make checks or money orders payable to:**
    - **SOVAH School of Health Professions** and
    - **Include the applicants first and last name in the memo section of the check.**
    - **Please do not mail cash!**
    - **Mail to: SOVAH School of Health Professions**
      109 Bridge Street
      Suite 200
      Danville, VA 24541
  - **In order to reduce delays and potential errors, please place all documents in a sealed envelope and mail as one complete packet.**
- **Applicants are selected in accordance with non-discriminatory policies.**
- **Due to limited enrollment, applicants who meet all requirements are not guaranteed acceptance into this program.**
- **Completely fill in all items on this application; type or print legibly.**

The Admissions Committee will review only applicant files that are **complete**. It is the applicant's responsibility to ensure that the school receives all required documentation. After selections have been made, all applicants will be notified whether selected, not selected, or placed on an alternate list. Selected applicants will be required to submit an admission fee; undergo drug screening and criminal background check; submit a completed health assessment form, immunization record, and current CPR certification.

Title IX - Notice of Non-discrimination Policy

The *SOVAH School of Health Professions* does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities. Inquiries and/or concerns regarding the non-discrimination policies of The *School of Health Professions* may be addressed by contacting our Title IX Officer by phone or email @; 434-799-2271 or Mary.thomas1@lpnt.net. The Title IX Coordinator may also be reached by US Mail at Mary Thomas, **Title IX Coordinator, School of Health Professions, 109 Bridge Street-Suite 200, Danville, VA 24541.** For further information, visit http://wdcrobcolp01.ed.gov/CFAPPS/OCR/contactus.cfm for the address and phone number of the office that serves your area, or call 1-800-421-3481.

APPLICANT INFORMATION

Name _____
Last *First* *Middle* *Maiden*

If different, include your last name as it appears on your college transcript:

_____

Mailing Address _____
Street *City* *State* *ZIP Code*

Telephone: *Home* (____) _____ *Work* (____) _____ *Cell* (____) _____

**Email Address: _____ Are you a U.S. citizen? ☐ Yes ☐ No

(This is our PRIMARY means of communicating with you. Please check email frequently!)**

In case of emergency call: Contact #: (____) _____ Relationship: _____

APPLICANT INFORMATION

Have you ever been convicted of or are you presently under indictment for any felony or misdemeanor offense **other than** traffic violations? * ☐ Yes ☐ No If yes, please explain in an attached letter.

***Information is subject to verification through a REQUIRED Criminal History Background check.**

Attention Applicants: The Board of Health Professions and/or the American Registry of Diagnostic Medical Sonographers "may refuse to admit a candidate to any examination, or may refuse to issue a license or certificate to any applicant" based on a number of both criminal and/or unprofessional conduct reasons. If there is any question, applicants may wish to complete the ARDMS Ethics Review Pre-Application. This may be found on the website at https://www.ardms.org/wp-content/uploads/pdf/Compliance-Policies-ARDMS.pdf

---

Do you have a mental, physical, or chemical dependency condition, which could interfere with your current ability to practice in the healthcare field?

☐ Yes ☐ No **If you answered yes, please explain in detail on a separate sheet and attach to this application.**

EMPLOYMENT HISTORY

Include all employment within the past five years, beginning with your present or last employment.

1. Employer _____

   City/State _____ Dates Employed: From _____ To _____

   Job Responsibilities _____

   Reason for Leaving _____

2. Employer _____

   City/State _____ Dates Employed: From _____ To _____

   Job Responsibilities _____

   Reason for Leaving _____

RECOMMENDATIONS/REFERENCES

Submit three (3) completed professional or academic recommendation/reference sheets (such as a recent employer, teacher, and/or counselor.), **NOT RELATIVES, FRIENDS, OR CLERGY**. Each person serving as a reference must complete the form, place it in an envelope, seal the envelope and sign across the back flap, and return the sealed envelope to you. Include these sealed envelopes with your application. References not meeting the above criteria are considered invalid.

STUDENT ESSAY

On a separate sheet, please write a brief essay addressing each of the following:

- Your experiences and activities including **awards/honors, volunteer or community service**
- Your reason for selecting this career and your reason for desiring to enter this school
- Your perception of your intellectual capability to complete this program
- Your plans and aspirations for the future
- Why do you think communication and critical thinking are important skills for a health professional to possess?

APPLICATION CHECK LIST (Things to be submitted)

- ☐ Completed Application
- ☐ Application Fee
- ☐ 3 Recommendations/References
- ☐ Essay
- ☐ College Transcripts
- ☐ ASVAB Test Results (optional)

EDUCATION / PRE-REQUISITE COURSES

List in chronological order, any colleges, universities, and vocational/technical schools which you have attended. (Attach an additional sheet if needed!) Please request transcripts from each institution you attended and either send to the program directly or include with application!

1. Name of School _____ City/State _____
   Dates Attended: *From* _____ *To* _____ Graduation Date _____
   Degree Obtained: _____
2. Name of School _____ City/State _____
   Dates Attended: *From* _____ *To* _____ Graduation Date _____
   Degree Obtained: _____

Have you attended another school or similar program? ☐ Yes ☐ No

If yes, what program and school did you attend? _____

Graduation Date: _____

ADDITIONAL COLLEGE LEVEL COURSES (If not on original transcript)

Courses marked with an *** are strongly encouraged.** Please include "official transcripts" for these courses. Please check with the Program Director @ (434)799-2271 before scheduling placement tests or enrolling in any general education courses!

Please indicate your current status in the following college courses.
(Course numbers are current VCCS numbers, out of state course numbers will vary, but must be their equivalent.)

Course # (or equivalent)	**Course**	Credit Hours	Currently Enrolled (Y or N)	Complete (Y or N)	College
***BIO 142**	***Human Anatomy and Physiology II**	4			
***HLT 143**	***Medical Terminology I**	3			
***MTH Elective**	**MTH 154 or MTH 155 or higher**	3			

LICENSE

Supply certification/licensing board and identifier: _____

Please check the appropriate box.

Has your license/certification ever been:	Yes	No	N/A
Voluntarily surrendered to any licensing authority?			
Placed on probation?			
Suspended?			
Revoked?			
Otherwise disciplined?			
Have you ever been the subject of an investigation by any licensing board?			

If you answered yes to any of the above questions, explain in detail on a separate sheet and attach to this application.

DISCLOSER

CERTIFICATION, ACKNOWLEDGEMENT, AND AUTHORIZATION:

Please read the following statement carefully before signing.

I certify that the information contained in this application is true and complete. I understand that if I am found to have provided false or incomplete information on this application, the Program may cancel my application or, if I have been accepted, remove me from the Program.

I understand that if I am enrolled in the SOVAH - School of Health Professions, I will be subject to and required to abide by all of the School's policies, procedures, and practices, including (among others) their Program on Illegal Drugs and Alcohol. I agree that I will abide by these policies, procedures, and practices, including any that the School may add or modify during my enrollment.

I understand and acknowledge that the SOVAH - School of Health Professions has a legitimate need to know the details of my education and employment history in order to consider my application. I hereby authorize and request for my former schools, employers, and other institutions or persons with information about my education and employment history to provide to the SOVAH - School of Health Professions any information or records the School may request about my education or employment history. I hereby release from any liability of any kind any institution, company, or person who provides such information or records and any authorized representative of the School who requests such information or records.

(Note: The SOVAH - School of Health Professions is firmly committed to maintaining an environment free of the influence of illegal drugs and alcohol. The School maintains the right to require any student to undergo testing to determine his or her fitness for duty, such as to determine whether the student may pose a potential danger of harming patients or may have a medical problem that interferes with his or her ability to perform duties safely or effectively. In keeping with this practice, a student may be tested for drugs or alcohol to help determine that person's fitness for duty. For more information, please refer to the School of Health Professions Policy on Illegal Drugs and Alcohol.)

_____ _____

Applicant's Signature Date

SOVAH
School of Health Professions

CONFIDENTIAL RECOMMENDATION/REFERENCE FORM

Section 1 (to be completed by applicant)

Indicate your decision regarding a waiver of the right of access before giving it to the person who will submit it. Give the form and a self-addressed and stamped referral envelope to the person making the recommendation. Have him or her place the completed recommendation into the envelope, seal it and sign across the seal. The envelope should be returned to you and you should return it with your application. Do not return separately.

Applicant's Name _____

Last **First** **M.I.**

The Family Educational Rights and Privacy Act of 1974 and its amendment's guarantee students' access to their educational files and all information concerning them. Students are also permitted to waive their right of access to recommendations. The following signed statement is the applicant's wish regarding this recommendation.

( ) I waive my right to inspect the contents of the following recommendation.

( ) I do not waive my right to inspect the contents of the following recommendation.

_____

Applicant's Signature

This individual wishes you to write a letter of recommendation on behalf of his or her application to the SOVAH - School of Health Professions General Sonography Program. Your objective evaluation of the applicant's qualifications would be most appreciated.

Section 2 (to be completed by the person making this recommendation)

Name of person making recommendation

_____

Last **First** **M.I.**

How long and in what capacities have you known the applicant?

_____

_____

Please specify the group to which you are comparing this applicant:

( ) High school students ( ) Undergraduate college students ( ) Employees

Characteristic	Excellent Upper 10%	Good Upper 11-20%	Average 21-59%	Below Average <60%	No Basis For Judgment
Overall intellectual ability					
Understanding fundamentals of chosen occupation					
Written communication skills					
Verbal communication skills					
Ability to organize and apply facts and ideas					
Manual dexterity					
Ability to handle stressful situations					
Aptitude for higher education					
Intellectual curiosity					
Motivation					
Potential as a health care provider					
Overall Rating					

We realize that check off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments regarding the potential of the applicant to be a health care practitioner including remarks concerning maturity, personality, extracurricular activities or any other factors that you feel are important concerning the applicant's aptitude for successful performance within the educational process and/or profession.

Your overall assessment of the applicant as to his or her ability to complete an educational program in Sonography:

( ) Strongly recommended **( ) Recommended**

( ) Recommend with reservations* **( ) Do not recommend**

***Please explain on separate sheet if necessary.**

_____ _____

Signature **Date**

Name

Title

Street Address

City **State** **Zip**

Please place the completed form in the envelope provided by the applicant.
Please be sure to seal the envelope and sign across the seal before returning it to the applicant.
Thank you for assisting us with our self-managed application process.

SOVAH
School of Health Professions

CONFIDENTIAL RECOMMENDATION/REFERENCE FORM

Section 1 (to be completed by applicant)

Indicate your decision regarding a waiver of the right of access before giving it to the person who will submit it. Give the form and a self-addressed and stamped referral envelope to the person making the recommendation. Have him or her place the completed recommendation into the envelope, seal it and sign across the seal. The envelope should be returned to you and you should return it with your application. Do not return separately.

Applicant's Name _____
Last **First** **M.I.**

The Family Educational Rights and Privacy Act of 1974 and its amendment's guarantee students' access to their educational files and all information concerning them. Students are also permitted to waive their right of access to recommendations. The following signed statement is the applicant's wish regarding this recommendation.

( ) I waive my right to inspect the contents of the following recommendation.

( ) I do not waive my right to inspect the contents of the following recommendation.

_____
Applicant's Signature

This individual wishes you to write a letter of recommendation on behalf of his or her application to the SOVAH - School of Health Professions -General Sonography Program. Your objective evaluation of the applicant's qualifications would be most appreciated.

Section 2 (to be completed by the person making this recommendation)

Name of person making recommendation

_____
Last **First** **M.I.**

How long and in what capacities have you known the applicant?

_____

_____

Please specify the group to which you are comparing this applicant:

( ) High school students ( ) Undergraduate college students ( ) Employees

Characteristic	**Excellent** Upper 10%	**Good** Upper 11-20%	**Average** 21-59%	**Below** Average <60%	**No Basis** For Judgment
Overall intellectual ability					
Understanding fundamentals of chosen occupation					
Written communication skills					
Verbal communication skills					
Ability to organize and apply facts and ideas					
Manual dexterity					
Ability to handle stressful situations					
Aptitude for higher education					
Intellectual curiosity					
Motivation					
Potential as a health care provider					
Overall Rating					

We realize that check off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments regarding the potential of the applicant to be a health care practitioner including remarks concerning maturity, personality, extracurricular activities or any other factors that you feel are important concerning the applicant's aptitude for successful performance within the educational process and/or profession.

Your overall assessment of the applicant as to his or her ability to complete an educational program in Sonography:

( ) Strongly recommended **( ) Recommended**

( ) Recommend with reservations* **( ) Do not recommend**

***Please explain on separate sheet if necessary.**

_____ _____

Signature **Date**

_____

Name

_____

Title

_____

Street Address

_____

City **State** **Zip**

Please place the completed form in the envelope provided by the applicant.
Please be sure to seal the envelope and sign across the seal before returning it to the applicant.
Thank you for assisting us with our self-managed application process.

SOVAH
School of Health Professions

CONFIDENTIAL RECOMMENDATION/REFERENCE FORM

Section 1 (to be completed by applicant)

Indicate your decision regarding a waiver of the right of access before giving it to the person who will submit it. Give the form and a self-addressed and stamped referral envelope to the person making the recommendation. Have him or her place the completed recommendation into the envelope, seal it and sign across the seal. The envelope should be returned to you and you should return it with your application. Do not return separately.

Applicant's Name _____
Last **First** **M.I.**

The Family Educational Rights and Privacy Act of 1974 and its amendment's guarantee students' access to their educational files and all information concerning them. Students are also permitted to waive their right of access to recommendations. The following signed statement is the applicant's wish regarding this recommendation.

( ) I waive my right to inspect the contents of the following recommendation.

( ) I do not waive my right to inspect the contents of the following recommendation.

_____
Applicant's Signature

This individual wishes you to write a letter of recommendation on behalf of his or her application to the SOVAH - School of Health Professions General Sonography Program. Your objective evaluation of the applicant's qualifications would be most appreciated.

Section 2 (to be completed by the person making this recommendation)

Name of person making recommendation

_____
Last **First** **M.I.**

How long and in what capacities have you known the applicant?

_____

_____

Please specify the group to which you are comparing this applicant:

( ) High school students ( ) Undergraduate college students ( ) Employees

Characteristic	**Excellent** Upper 10%	**Good** Upper 11-20%	**Average** 21-59%	**Below** Average <60%	**No Basis** For Judgment
Overall intellectual ability					
Understanding fundamentals of chosen occupation					
Written communication skills					
Verbal communication skills					
Ability to organize and apply facts and ideas					
Manual dexterity					
Ability to handle stressful situations					
Aptitude for higher education					
Intellectual curiosity					
Motivation					
Potential as a health care provider					
Overall Rating					

We realize that check off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments regarding the potential of the applicant to be a health care practitioner including remarks concerning maturity, personality, extracurricular activities or any other factors that you feel are important concerning the applicant's aptitude for successful performance within the educational process and/or profession.

Your overall assessment of the applicant as to his or her ability to complete an educational program in Sonography:

( )	**Strongly recommended**	**( )**	**Recommended**
( )	**Recommend with reservations***	**( )**	**Do not recommend**

***Please explain on separate sheet if necessary.**

_____ _____

Signature **Date**

_____

Name

_____

Title

_____

Street Address

_____

City **State** **Zip**

Please place the completed form in the envelope provided by the applicant.
Please be sure to seal the envelope and sign across the seal before returning it to the applicant.
Thank you for assisting us with our self-managed application process.