

# UNC HOSPITALS SCHOOL OF COMPUTED TOMOGRAPHY

Please complete in neat **print** or **type**. If you have questions, please call the number listed below.

**Wes Kaczmarek R.T. (R)(N)(CT)**  
**Radiology Administration-Nuclear Medicine**  
**101 Manning Drive**  
**UNC Hospitals**  
**Chapel Hill, N.C. 27514**  
**(984) 974-8800 Fax: (984) 974-8596**  
[wesley.kaczmarek@unchealth.unc.edu](mailto:wesley.kaczmarek@unchealth.unc.edu)

NAME:	LAST FOUR OF SSN:
CURRENT ADDRESS:	
DATE OF BIRTH:	
PHONE:	EMAIL:
PERMANENT ADDRESS (If different than above):	
PHONE:	

## EDUCATIONAL BACKGROUND: (ATTACH ADDITIONAL PAGES IF NEEDED)

RADIOLOGIC SCIENCE	
PROGRAM NAME:	
PROGRAM ADDRESS:	
DATES ATTENDED:	DATE COMPLETED:
CERTIFICATION:	
ORGANIZATION:	YEAR:
BOARD CERTIFICATIONS:	

NMADF

DATE

/INITIALS: \_\_\_\_\_

**ADDITIONAL EDUCATIONAL EXPERIENCES:**

COLLEGE/UNIVERSITY:
LOCATION:
DATES ATTENDED:
DEGREE:

**PROFESSIONAL EXPERIENCES: (Resume is acceptable)**

Describe professional experiences beginning with your most recent position. Information to be included is past positions & titles, dates, responsibilities and places worked. Any additional information that you might wish to include which could enhance your chances of admission into the Computed Tomography program is welcomed. (If need be, attach additional sheets or use the back of this one)

NMADF

DATE /INITIALS: \_\_\_\_\_

**ACADEMIC AND PROFESSIONAL HONORS**

Describe any academic achievements or professional recognition awards you have received.

Describe any clinical training or coursework you have done that you would like considered by the admissions Committee.

Add any additional information you wish to be considered by the admissions committee when evaluating your application.

Have you ever been convicted of a crime? \_\_\_\_\_

If yes, please describe?

To the best of my knowledge, my responses to the requested information are forthright, honest and true. I understand that this information will be used solely as a means of evaluating me for entrance into the Computed Tomography Program.

APPLICANT NAME:(Please print): \_\_\_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**APPLICANT DEMOGRAPHIC SHEET**

This information is for statistical purposes only and will not be used in any admissions decisions.

**Male:** \_\_\_\_\_ **Female:** \_\_\_\_\_

**Ethnic Group:** American Indian or Alaskan Native: \_\_\_\_\_

Asian or Pacific Islander: \_\_\_\_\_

Black (Not of Hispanic Origin): \_\_\_\_\_

Hispanic: \_\_\_\_\_

White: \_\_\_\_\_

Other \_\_\_\_\_

**Marital Status:** Single: \_\_\_\_\_

Married: \_\_\_\_\_

Separated: \_\_\_\_\_

Divorced: \_\_\_\_\_

**Legal Residence:** County: \_\_\_\_\_

State: \_\_\_\_\_

**Citizenship:** \_\_\_\_\_

**Veteran:** Yes: \_\_\_\_\_ No: \_\_\_\_\_

Are you aware that you presently have any physical or learning disabilities?

Yes: \_\_\_\_\_ No: \_\_\_\_\_