Application For Admission: Medical Dosimetry Certificate Program
University of North Carolina Hospitals
Department of Radiation Oncology

Information and Instructions

1. Use this application only for admission to The UNC Hospitals Medical Dosimetry Certificate Program.

2. Your application will not be processed until *all* official transcripts have been received by the Program Director from each college/university attended.

3. Your application, including relevant work experience, all college transcripts and three letters of reference, must be submitted in its entirety by the deadline date of February 1 of each year, for planned enrollment July of that year.

4. Applicants whose first language is not English must submit official TOEFL scores. Minimum scores of 550 (paper-based) or 213 (computer-based) are required for admission consideration, but do not ensure acceptance.

5. If contacted, interviews are required for admission into the program. *Being granted an interview does not guarantee admission however.*

6. Current CPR certification is required prior to enrollment. Computer literacy is also expected.

Return the application and all other documentation to:

Jessica Church, MPH, RT(R)(T), CMD, Program Manager
Certificate Program in Medical Dosimetry
Department of Radiation Oncology, CB #7512
The University of North Carolina Hospitals
101 Manning Drive
Chapel Hill, NC 27514
USA

The University of North Carolina Hospitals
Department of Radiation Oncology
Medical Dosimetry Certificate Program

Application For Admission

1. Applying to enter in July of calendar year: _____

2. Name:

   Last: _____

   First: _____

   Middle: _____

   Prefix/Suffix: _____

3. Telephone Number: _____

4. E-Mail Address: _____

5. Permanent Mailing Address:

_____
Street Address, Line 1

_____
Street Address, Line 2

_____
City State Zip Code

6. Current Mailing Address (if different from above):

Street Address, Line 1

Street Address, Line 2

City State Zip Code

7. References

Please list the name, address and title of at least three persons who are familiar with your academic and/or professional competence, and who you have already asked to submit a letter of recommendation on your behalf using the enclosed forms. Additional references are permitted.

Reference #1: First MI Last Title

Street Address, Line 1

Street Address, Line 2

City State Zip Code

Phone Number E-Mail Address

Reference #2: First MI Last Title

Street Address, Line 1

Street Address, Line 2

City State Zip Code

Phone Number E-Mail Address

Reference #3: First MI Last Title

Street Address, Line 1

Street Address, Line 2

City State Zip Code

Phone Number E-Mail Address

Reference #___: First MI Last Title

Street Address, Line 1

Street Address, Line 2

City State Zip Code

Phone Number E-Mail Address

Reference #___: First MI Last Title

Street Address, Line 1

Street Address, Line 2

City State Zip Code

Phone Number E-Mail Address

For additional references, please print out and attach additional pages like this one.

8. On the following page and using the table provided, please list ALL post-secondary schools attended in chronological order. Remember that an OFFICIAL transcript from each school is also required. Begin with the first school attended.

9. The next page contains another table to be used to list ALL work and professional experience, if applicable. Please list in chronological order.

Post-Secondary Education Form

School Name	Location	Dates Attended	Certificate/Degree Received (if any)	Major	Date Degree Conferred

Prior Work Experience Form

Employer	Employer Address	Dates Employed (from - to)	Full or Part Time?	Type of Position

10. Please submit a short essay describing your reasons for wanting to join The UNC Hospitals Medical Dosimetry Certificate Program. The narrative should discuss career goals, leadership positions and previous healthcare experience, as well as any relevant community service. Feel free to mention any additional work or significant life experiences that relate to motivation, qualifications, or academic record.

11. I certify that the information submitted herein is true and correct to the best of my knowledge.

I understand that willfully withholding information or making false statements in this application may be used as the basis for denial of admission or for dismissal.

❑ Yes ❑ No

Signature of Applicant: _____

Date: _____

The University of North Carolina Hospitals
Department of Radiation Oncology
Medical Dosimetry Certificate Program

For Academic Year Beginning: July, 20__

Letter of Recommendation Form

Applicant's Name:

Last

First

Middle

Please have this form filled out by three or more professional references of your choice, following the guidelines in the application.

In accordance with the provision of the Family Educational Rights and Privacy Act of 1974, P.L.- 390 (as amended), with specific reference to Section 438 (a) (1) (B) and subtitle A sections 99.7, 99.11, and 99.12:

I understand that federal legislation provides me with a right of access to this recommendation after I matriculate; while this right may be waived, no school or person can require me to waive this right.

I ❑ DO ❑ DO NOT waive my right of access to this recommendation.

Applicant's Signature Date

To the Recommender:

The individual named on the previous page has applied to The University of North Carolina Hospitals Certificate Program in Medical Dosimetry.

We are seeking any and all information that will aid us in the selection of motivated, capable students for our program. It is important that such students be able to complete both their didactic and clinical components successfully in a short and intensive one year program, taught roughly at the level of a second or third year baccalaureate-level student. The applicant should also possess standards of ethics and professionalism necessary to become a member of a seasoned healthcare team.

The applicant has selected you as an individual who can provide such valuable insights. We would appreciate your candid evaluation of the applicant's qualifications.

If the applicant has waived his or her right of access (see previous page), your recommendation will remain confidential. If however, the applicant does not waive right of access or sign the waver statement, the student will be permitted to review this reference upon request.

Finally, we realize that you may be asked to provided numerous letters of recommendation for students seeking to advance their education. On behalf of both the applicants and ourselves, we thank you in advance for your attention to this matter and are very appreciative of your efforts.

Please return this recommendation form as soon as possible to:

Jessica Church, MPH, RT(R)(T), CMD, Program Manager
Certificate Program in Medical Dosimetry
Department of Radiation Oncology, CB#7512
The University of North Carolina Hospitals
101 Manning Drive
Chapel Hill, NC 27514
USA

Please type or print:

1. How long and in what capacity have you known this applicant?

2. Please include any additional comments that will aid us in obtaining a complete picture of this applicant's abilities and potential as both a student and a dedicated healthcare professional.

3. Personal and Professional Appraisal

For each of the following indicators listed below, please rate this applicant according to the following Likert scale:

1 = Poor
2 = Average
3 = Good
4 = Excellent
5 = Not Applicable (or indicate "N/A")

Academic Potential: ____	Motivation For A Career In Medical Dosimetry: ____
Leadership Skills: ____	Sense of Responsibility: ____
Technical Skills: ____	Ability To Work With People: ____
Oral Communication Skills: ____	Ability to Adapt to New Situations: ____
Written Communication Skills: ____	Ability to Work Independently: ____
Problem Solving Skills: ____	Reliability: ____

Overall Recommendation for This Applicant (select one):

❏ Strongly recommend
❏ Recommend
❏ Recommend with reservations
❏ Do not recommend

Recommender Name and Title

Street Address, Line 1

Street Address, Line 2

City State Zip Code

Phone Number E-Mail Address

Signature Date