Diagnostic Medical Sonography
Application Packet

Thank you for your interest in the Diagnostic Medical Sonography program at Jones County Junior College. We accept our new class in the fall each year. The deadline for application is March 30th for all required documents. Incomplete applications will not be considered. We accept 8 students and an alternate each year.

APPLICATION REQUIREMENTS:

- Be accepted to or eligible for enrollment at Jones County Junior College
- Have a minimum composite score of 17 on the American College Test (ACT)
- Have a minimum G.P.A. of 2.5
- Have a Bachelor’s of Science degree from an accredited institution in any field (preference will be given to medical and/or science related fields)
  
  OR

- Be a Registered Radiologic Technologist (A.R.R.T.) and in good standing with the American Registry of Radiologic Technologists, or be registry eligible with the American Registry of Radiologic Technologists. (Documentation must be provided as to status.)
  
  OR

- Hold a degree/diploma from an accredited two year allied health program (program must include patient care and clinical training).
- Completed the Diagnostic Medical Sonography Application Package
- Completed Anatomy and Physiology I and II with a “C” or better.
- Completed Physics, Physical Science, or Radiologic Physics
- Algebra or College Algebra (preference will be given to college algebra)

ADMISSION PROCEDURE:

- Apply for admission to Jones County Junior College
- Complete the Diagnostic Medical Sonography program application and return prior to deadline
- Submit official transcripts to registrar office at Jones County Junior College
- Submit transcripts (official or unofficial), official ACT scores, and references to Diagnostic Medical Sonography office.

Selection of Applicants into the Program:

- Selection of students into the program is very competitive. The above listed requirements are the minimum accepted scores and do not guarantee admission into the program.
- Selection is based on ACT score, college GPA, selected course work, work experience, and interview results. Eight students are accepted and one alternate.
- Students must maintain 75% in the didactic course work and 85% in the clinical coursework once accepted.
- Random drug screens will be conducted throughout the program.

JCJC Diagnostic Medical Sonography program, 900 S. Court Street, Ellisville, MS 39437
(601) 477-2416

Revised May 2015
Name ____________________________ (Last) ______________________ (First) ______________________ (Middle)

Resident Address ____________________________ ____________________________________________

(Street) ____________________________ (State) ____________________________ (Zip code) ____________

(City) ____________________________

Social Security Number ___-___-___ Telephone ____________________________

Email address ____________________________________________

School I.D. Number - ____________ __________________________________________

Are you at least 18 years of age? YES ____ NO ____ Who referred you to us? ____________________________

How far do you live from the college? ____________________________

How will you get to and from school? ____________________________

Do you have personal obligations that would cause you to miss school? YES ____ NO ____

If accepted do you plan to work or attend any other school? YES ____ NO ____ If yes, please indicate nature
and weekly hours: __________________________________________

Are you physically and mentally able to perform the duties for which you have applied? YES ____ NO ____ If not, could
you perform these functions if a reasonable accommodation were made? YES ____ NO ____ Please explain.

In case of emergency notify: ____________________________ (Name) ____________________________ (Relationship)

Address ____________________________________________ Telephone Work ________ Home ________

EDUCATION

School name ____________________________ Address ____________________________ Yrs. Attended ________ Major ____________________________

Have you ever applied for admission to any other School of Diagnostic Medical Sonography? YES ____ NO ____
** If yes, School name ____________________________ Date ____________________________

Have you ever been enrolled in a school of Diagnostic Medical Sonography? YES ____ NO ____ If yes, please
indicate school name. ____________________________ Date ____________________________

Why was your education interrupted? __________________________________________

Have you ever been convicted of a crime? YES ____ NO ____ If yes explain) ____________________________

Revised May 2015
**Conviction of a crime is not an automatic bar to enrollment. All circumstances will be considered.**

WORK HISTORY: Please list your most recent employer first.

<table>
<thead>
<tr>
<th>Employer Name and Address</th>
<th>Position</th>
<th>Dates</th>
<th>Reason for leaving</th>
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May we contact the employers listed above? _YES_ _NO_

MILITARY EXPERIENCE: Branch ____________________ Rank Achieved ____________________

Special Training/Schools _______________________________________________________________

Date entered ____________________ Date Discharged ____________________

REFERENCES: (3) List references other than relatives. Please include address and telephone.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Equal opportunity is given to all applicants regardless of race, creed, national origin, sex, age, or individuals with disabilities.

I certify that the answers given me to the foregoing questions and statements are true and complete to the best of my knowledge and that I have withheld nothing that would, if disclosed, affect this application unfavorably. I authorize the companies, schools, or persons named herein to give information regarding my employment, character, and qualifications, together with any information they may have regarding me, whether or not it is in their records. I hereby release said companies, schools, or persons from all liability for any damage for issuing this information. I understand that any misleading or incorrect statements may render this application void, and if enrolled, cause my immediate dismissal.

My health information will be recorded on the medical report form supplied by the Sonography Program and returned to the Program Director prior to beginning class. If selected for entry into the program, I agree to submit myself to a physical examination, by my physician, at my expense.

If accepted into the program, I authorize the school to release to perspective employers any information regarding my enrollment with the school or the information set forth in this application or gained by the school from any other companies, schools, or persons named in this application to give information regarding my employment, character, qualifications, and information they may have, regarding me, whether or not it is in their records. I hereby release the school from all liability for any damage for issuing this information.

Applicant Signature: ___________________________ Date: __________________________

Revised May 2015
APPLICANT INFORMATION

On the space provided below, briefly tell us about yourself. Please include the reasons for your interest in Diagnostic Medical Sonography, future plans if accepted into the program and any additional information you wish to include. (PLEASE PRINT)

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Revised May 2015
CONFIDENTIAL REFERENCE FORM

PART I - To be completed by the applicant and given to a previous instructor and a past employer for completion. The third form may be given to someone from another professional field.

Name of Applicant ________________________________________________________

Mailing Address __________________________________________________________ Telephone ________________________

I hereby waive my right of access to this confidential recommendation as provided in the Educational Rights and Privacy Act of 1974. (Optional)

Signature ________________________________________________________________ Date ______________________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

PART II - To the person serving as a reference. Please note the wavier statement above. Once you have completed the enclosed form please return it to: Jones County Junior College, Diagnostic Medical Sonography Program, 900 South Court Street, Ellisville, MS 39437 before March 30.

Please mark the most appropriate column beside each trait listed below.

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* Sonography is a very “tech-dependent” field so honesty is vital. Sonographers are the “eyes of the doctor” and mistakes can cost lives. You may respond with “prefer not to answer” if you are uncomfortable answering honestly.

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

__________________________________________________________________________

__________________________________________________________________________

Revised May 2015
Describe major strengths of the applicant.
1. _____________________________________________________________________________________
2. _____________________________________________________________________________________
3. _____________________________________________________________________________________

Describe major weaknesses of the applicant.
1. _____________________________________________________________________________________
2. _____________________________________________________________________________________

Please include any additional information you feel would be beneficial to the Admissions Committee in its consideration of this applicant.
___________________________________________________________________________________

PLEASE INDICATE YOUR RECOMMENDATION OF THIS APPLICANT FOR ACCEPTANCE INTO THIS HEALTH RELATED EDUCATIONAL PROGRAM.

HIGHLY RECOMMEND   RECOMMEND   RECOMMEND WITH RESERVATION   PREFER NOT TO RECOMMEND
______   ______   ______   ______

Signature____________________________________________________________Date______________________

Name (Please print or type)       Position/Title
_____________________________________________________________________________________________

Institution/Company
_____________________________________________________________________________________________

Address and telephone
_____________________________________________________________________________________________

May we contact you with questions? _____ yes _____ no

Additional Comments: ___________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

PLEASE RETURN THIS FORM NO LATER THAN March 30th.

Jones County Junior College
Diagnostic Medical Sonography
900 South Court Street
Ellisville, Mississippi 39437

Revised May 2015
CONFIDENTIAL REFERENCE FORM

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Telephone_________________________

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

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Revised May 2015
Describe major strengths of the applicant.
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PLEASE INDICATE YOUR RECOMMENDATION OF THIS APPLICANT FOR ACCEPTANCE INTO THIS HEALTH RELATED EDUCATIONAL PROGRAM.

HIGHLY RECOMMEND RECOMMEND RECOMMEND WITH RESERVATION PREFER NOT TO RECOMMEND
______ ______ ______ ______

Signature____________________________________________________________Date______________________

Name (Please print or type) Position/Title
_____________________________________________________________________________________________

Institution/Company
_____________________________________________________________________________________________

Address and telephone

May we contact you with questions? _____ yes _____ no

Additional Comments: ___________________________________________________________________
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PLEASE RETURN THIS FORM NO LATER THAN March 30th.

Jones County Junior College
Diagnostic Medical Sonography
900 South Court Street
Ellisville, Mississippi 39437

Revised May 2015
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How long have you known this applicant and in what capacity?

______________________________

Revised May 2015
Describe major strengths of the applicant.
1. ____________________________________________________________________________________
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3. ____________________________________________________________________________________

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Signature____________________________________________________________Date______________________

Name (Please print or type)________________________Position/Title________________________

Institution/Company______________________________________________________________

Address and telephone________________________________________________________________
May we contact you with questions? _____ yes _____ no
Additional Comments: __________________________________________________________________

_____________________________________________________________________________________

PLEASE RETURN THIS FORM NO LATER THAN March 30th.

Jones County Junior College
Diagnostic Medical Sonography
900 South Court Street
Ellisville, Mississippi 39437

Revised May 2015
Report of Medical Information

Name: ______________________________________________________________________

Address: ___________________________________________________________________

Social Security Number: ________________________ Telephone: ________________

I hereby authorize the information contained herein to be released to Jones County Junior College for such purpose, as they may desire, without prejudice to them. This information is to be kept in their confidential files. I understand that any false information I give for this record may result in the immediate termination of my enrollment in the program.

Applicant Signature: __________________________________ Date:____________________

Medical History

Please indicate if you have ever experienced any of the following. If you answer yes in any space, please explain in the space provided.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>YES</th>
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<tbody>
<tr>
<td>Epilepsy</td>
<td>Stomach Trouble</td>
<td>Back Trouble</td>
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<td>Fainting</td>
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<td>Operations</td>
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<td>Heart Trouble</td>
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<td>Cancer</td>
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<td>Accidents</td>
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<td>Rheumatism</td>
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<td>Nervousness</td>
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<td>Other (explain)</td>
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<td>Other (explain)</td>
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***Please include an explanation for any “YES” answer.

You must return this form with your application. Complete ONLY the front sheet. If you are selected for entry into the program, for which you have applied, a satisfactory physical examination, by the physician of your choice, will be required.

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Revised June 2013
Checklist for Turning In Materials

On or before March 30th make sure that you have:

__________ Submit the completed application form.

__________ Assure that the following items have been received:

__________ A.C.T. scores

__________ College transcripts from all college work showing the qualifying degree and all prerequisites

__________ Midterm grades, if applicable

__________ Reference forms (3)

__________ Two sets of A.C.T. scores and sealed official transcripts from the registrar of the previous institution in a sealed envelope: One must be given to the DMS Program Director. The other official transcript must be mailed to the JCJC Registrar’s office for admission to the JCJC.

__________ Reference letters should be returned by the person completing the reference form not by the applicant.

__________ Submit documentation of:

(1) A.R.R.T. Registry, in good standing OR Registry- eligible status with the A.R.R.T

   OR

(2) Transcripts verifying completion of two year allied health program or bachelor degree from an accredited facility.

Applicants who submit all the required materials and meet minimum requirements will be invited to an interview with the Program Director and/or DMS Admissions Committee.

Qualified applicants will be notified of the date, time and location of the interview by mail.

FAILURE TO SUBMIT ALL INFORMATION OR COMPLETE ALL REQUIREMENTS ON OR BEFORE THE DATES INDICATED WILL VOID THE APPLICATION.