Beaumont®

3601 West 13 Mile Road
Royal Oak, Michigan 48073-6769

Select the one program applying to:

__Nuclear Medicine Technology
__Radiation Therapy
__Histologic Technician
__Histotechnologist
__Medical Laboratory Science
__Clinical Oncology Massage

APPLICATION FOR ADMISSION TO THE BEAUMONT SCHOOLS OF ALLIED HEALTH

Today's Date	Start Date of Program Applying To

You must fully and accurately complete the Application for Admissions. Incomplete applications will not be considered.

Name	First	Middle	Last	Soc. Sec. No.

Present Address	Number	Street

City	State	Zip Code	Home Phone	Daytime Phone #

Permanent Address	Number	Street

City	State	Zip Code	Home Phone	Daytime Phone #

E-mail Address	Driver's License Number

Have you previously used other names for work or education records?

☐ Yes ☐ No If Yes, please provide:

Have you ever been employed by William Beaumont Hospital or any of its Hospital affiliates in any capacity? ☐ Yes ☐ No
Hire Date: ____________________________ Job Title: ____________________________

Are you over the age of 18?

☐ Yes ☐ No

Are you registered, certified or licensed by any professional medical state and/or national organization? (Please do not list any organization that may indicate the gender, sexual orientation, race, color, religion, national origin or ancestry of its members.)

☐ Yes ☐ No If yes, list organizations:

Registry, Certification or License No.	Serial Audit No.	Expiration Date
1.	1.	1.
2.	2.	2.
3.	3.	3 .

For licensed professionals, have you been or are you currently being investigated by Federal or State governments related to your participation in Medicare, Medicaid or other Federal health programs?

☐ Yes ☐ No If yes, please explain

Registry, Certification or License No.	Serial / Audit No.	Expiration Date
1.	1.	1.
2.	2.	2.
3.	3.	3 .

Have you ever been **discharged or suspended** from an educational program (including one to meet any certification requirement) or place of employment?

☐ Yes ☐ No If YES, please explain:

Have you ever been **subject to disciplinary action** in an educational program (including one to meet any certification requirement) or place of employment?

☐ Yes ☐ No If YES, please explain.

EMPLOYMENT BACKGROUND List in order, most recent position first. May we contact employer(s) for references? ☐ Yes ☐ No

NAME OF COMPANY TELEPHONE	☐ Contingent ☐ Full Time ☐ Part Time		DUTIES AND RESPONSIBILITIES
ADDRESS – Street, City, State, Zip	DATES		
	From	To	
STARTING POSITION			
FINAL POSITION			
SUPERVISOR'S NAME and PHONE NUMBER			
REASON FOR LEAVING			

NAME OF COMPANY TELEPHONE	☐ Contingent ☐ Full Time ☐ Part Time		DUTIES AND RESPONSIBILITIES
ADDRESS – Street, City, State, Zip	DATES		
	From	To	
STARTING POSITION			
FINAL POSITION			
SUPERVISOR'S NAME and PHONE NUMBER			
REASON FOR LEAVING			

NAME OF COMPANY TELEPHONE	☐ Contingent ☐ Full Time ☐ Part Time		DUTIES AND RESPONSIBILITIES
ADDRESS – Street, City, State, Zip	DATES		
	From	To	
STARTING POSITION			
FINAL POSITION			
SUPERVISOR'S NAME and PHONE NUMBER			
REASON FOR LEAVING			

Health care related experience / volunteerism	DATES: From	To

EDUCATIONAL BACKGROUND

SCHOOL	NAME AND ADDRESS OF SCHOOL	COURSE OF STUDY (MAJOR)	DATES	DID YOU GRADUATE?	LIST DIPLOMA OR DEGREE AND DATE
High School				☐ Yes ☐ No	
College #1			From To	☐ Yes ☐ No	
College #2			From To	☐ Yes ☐ No	
College #3 If there are additional colleges/universities attended, attach a separate sheet.			From To	☐ Yes ☐ No	
Other: (e.g., Trade School, Business School, Internship)			From To	☐ Yes ☐ No	

Were/Are you a member of the U.S. Armed Forces? ☐ Yes ☐ No If yes, what branch? Highest rank held:	Dates of Active Duty Month / Year To Month / Year Type of Separation/Discharge:

**Have you ever been convicted of a crime *(misdemeanor or felony)* other than a minor traffic violation? *Please be sure to include any major traffic offense such as DUI, OWUI, etc.* If Yes, provide date, location (county and state, disposition and results.

☐ Yes ☐ No If yes, provide date, location (county and state), disposition and results.

**Are there any felony arrests or any unresolved felony charges pending against you? If yes, give date, location (county and state) and nature of charges.

☐ Yes ☐ No If yes, give date, location (county and state) and nature of charges.

If admitted to the program, can you provide documentation establishing your identity and eligibility to be legally admitted as a Beaumont Schools of Allied Health student in the United States? (i.e., proof of citizenship or immigration status)

☐ Yes ☐ No

William Beaumont Hospital is a smoke-free and nicotine free institution. Will you be able to comply with this policy?

☐ Yes ☐ No

Are you legally authorized to work in the United States?

☐ Yes ☐ No

***William Beaumont Hospital conducts criminal record checks. Failure to divulge complete information will disqualify you from admission into a Beaumont Allied Health program. However, conviction will not necessarily disqualify you for admission into a Beaumont Allied Health program*

William Beaumont Hospital is an equal opportunity employer and complies with all laws prohibiting discrimination on the basis of race, color, age, sex, national origin, religion, citizenship, disability, height, weight, or marital status.

I hereby authorize an investigation of my past employment; activities and statements contained in this application and release from all liability and responsibility all persons, companies or corporations supplying such information.

- I understand that such information may include a record of disciplinary action assessed by previous employers, and hereby release such parties from any obligation to supply me with written notification of such disclosure.
- I certify that the above information is correct and understand that misrepresentation of the facts may be sufficient cause for termination from the program.
- I understand that any admission offer is conditional upon successful completion of a physical examination which includes: a drug, alcohol and nicotine screen; completion of education eligibility verification; and upon receipt of satisfactory references.
- I understand that William Beaumont Hospital will conduct a criminal background check.

Signature ____ Date ___________________________

Technical Standards and Essential Functions:

William Beaumont Hospital and its Education Programs will provide reasonable accommodations to a student's or applicant's disability provided that doing so would not fundamentally alter the nature of the program in which the student is admitted, or for which the applicant is applying. Individuals with knowledge of requiring accommodations should notify the Beaumont Program Director in writing within a reasonable time after acceptance into the program. Should an individual require a reasonable accommodation at any time during the program, the individual shall notify the program director in writing of such a need within a reasonable time of learning of the need of the accommodation. Failure to provide such written notification may affect an individual's rights under Michigan's Person with Disability Civil Rights Acts.

1. Please read the Technical Standards and Essential Functions found at **www.beaumont.edu/alliedhealth** on the Application or Admissions Requirements page under the program(s) to which you are applying.
2. Sign below that you have read the Technical Standards and Essential Functions for the program to which you are applying and whether you can perform them.

I have read the Technical Standards and Essential Functions for the program of my choosing, including mental and physical requirements. (Check one) ☐ Yes ☐ No If no, please explain:

I am able to perform the Technical Standards and Essential Functions of this position either with or without a reasonable accommodation. (Check one) ☐ Yes ☐ No If no, please explain:

SIGNATURE ______________________ DATE ______________________

RETURN TO:

Program Director
School of ____ *(Insert the program you are applying to)*
William Beaumont Hospital
3601 W. Thirteen Mile Road
Royal Oak, Michigan 48073-6769

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William Beaumont Hospital
Schools of Allied Health

RELEASE OF INFORMATION AUTHORIZATION

I, __________________________hereby authorize William Beaumont Hospital, its staff, and/or agents to request
(print name here)
information from, and consult with employers, educational institutions, law enforcement agencies, credit reporting companies, and individuals with whom I have been associated, and with others who may have information regarding my competence, character and qualifications, and any other sources deemed appropriate by William Beaumont Hospital .

I specifically authorize former and present employers to release, verify, and provide any information regarding my employment with them to William Beaumont Hospital or their agents. I release and hold harmless from liability all persons, entities or institutions who, in good faith and without malice, participate in gathering or exchanging information in this process.

I authorize, without reservation, any party or agency contacted by William Beaumont Hospital or their agents, to furnish the above mentioned information.

In the event that I am denied a position based entirely or partly on information obtained by William Beaumont Hospital, I understand that I have the right to make a request to William Beaumont Hospital to inquire about the information.

Signature: ____ DATE: ___________________________

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Beaumont Schools of Allied Health Recommendation Form

Program applying to:

☐ School of Radiation Therapy

☐ School of Nuclear Medicine Technology

☐ School of Medical Laboratory Science

☐ School of Histotechnologist

☐ School of Histologic Technician

Return to the applicant at:

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Name of applicant: ____

Applicant: Please follow the letter of recommendation guidelines, which appear on the BSAH website and complete the above section before submitting this form to your reference.

Reference: The applicant named above has applied to Schools of Allied Health at William Beaumont Hospital, Royal Oak, Michigan. To maintain confidentiality, please seal the return envelope, sign over the seal and return to the applicant.

We are interested in obtaining information that will aid us in selecting capable students. In view of these highly technical and professional careers, it is imperative that we know something more than a transcript reveals. Thus, the Admissions Committee will rely on your honest evaluation of this candidate, and truly appreciate your efforts in this regard. The applicant has selected you as someone who can give us such an appraisal. Your recommendation will remain confidential.

I. Acquaintance with Applicant

1. Length of time you have known the applicant: ______________________ months/years.

2. I have known the applicant as a/an:
   - ☐ student
   - ☐ advisee
   - ☐ teaching assistant
   - ☐ employee
   - ☐ other: ______________________________

3. My interaction with the applicant was as a/an:
   - ☐ instructor in one class
   - ☐ instructor in several classes
   - ☐ curriculum or major advisor
   - ☐ teaching/research supervisor
   - ☐ employer/supervisor
   - ☐ other: ______________________________

II. Comments (use an extra sheet if needed) Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional.

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Name of applicant: ____

III. Professional Appraisal: (Please check the category that best indicates your evaluation of the applicant in terms of listed characteristics.

Characteristics Evaluated		Excellent	Above Average	Average	Below Average	**No Basis for Evaluation
Professional Qualities	**a. Appearance (dress, grooming, etc.)**					
	b. Reliability					
	c. Integrity					
Communication Skills:	**a. Oral**					
	b. Written					
	c. Listening					
Motivation:	**a. Attitude**					
	b. Initiative					
	c. Punctuality/Attendance					
	d. Leadership					
Ability:	**a. Academic Potential**					
	b. Work with People					
	c. Adapt to New Situations					
	d. Analyze Problems and Solve them Effectively					
	e. Interaction with Patients*					
	f. Work Independently					
Quality of Work:	**a. Organization**					
	b. Accuracy					
	c. Technical Competency					
	d. Professional Competency*					
Maturity:	**a. Judgment**					
	b. Emotional Stability					
	c. Sense of Responsibility					
	d. Sense of Reasoning					

*Only those who have had an opportunity to observe the applicant in a health setting should complete this category.
**This indicates you have not had the opportunity to observe the applicant in a situation demonstrating this characteristic.

IV. Recommendation for Acceptance

☐ Strongly recommend
☐ Recommend
☐ Recommend with reservations as noted in the comment section
☐ Do not recommend

Please Type or Print

YOUR NAME	TITLE
ORGANIZATION / BUSINESS / INSTITUTION	CONTACT PHONE NUMBER.
ADDRESS (CITY, STATE, ZIP CODE)	
SIGNATURE	DATE

Please note: It is not possible to thank each individual personally for completing a recommendation form. We want you to know, however, that we are aware of the time required and both we and the applicant are most appreciative of your response.