



# Southwestern Michigan College MRI/EEG/Radiography/Respiratory Therapy/Cardiovascular Technician Program Application

## Application Checklist

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Complete the Full Checklist BEFORE submitting.

### Forms to Be Signed

- \_\_\_\_\_ Application to Begin Program
- \_\_\_\_\_ Health Record – Physicians Form
- \_\_\_\_\_ Health Record – Applicants Form
- \_\_\_\_\_ Criminal Background Check Consent Form

### Other Required Documentation

- \_\_\_\_\_ Copy of Driver's License
- \_\_\_\_\_ Proof of U.S. citizenship, legal permanent residence, or valid non-immigrant status that permits study in the United States or Valid DACA Approval.

\*Acceptable documentation:

- **U.S. Citizenship** - birth certificate, passport, certificate of naturalization
- **Legal Permanent Residence** - permanent resident card (green card)
- **Non-Immigrant Status** - I-20 Certificate of Eligibility for F-1 students or visa stamp + I-94 record or I-797 Approval Notice for Change of Status + I-94 record
- **DACA** - I-797 Approval notice for consideration of Deferred Action of Childhood Arrivals.

### Other Requirements

- \_\_\_\_\_ SMC Student ID picture taken. This may be done at the Dowagiac Campus in the Student Activity Center or at the Niles Campus Main Office



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Complete and return to the Nursing and Health Services Department. Electronic signatures are not accepted.

## NAME

Last: \_\_\_\_\_ First: \_\_\_\_\_ Student ID# \_\_\_\_\_

## LOCAL ADDRESS

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PHONE: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

SMC EMAIL: \_\_\_\_\_@swmich.edu NON-SMC EMAIL: \_\_\_\_\_

**For which program are you applying for?** (Check one)

MRI \_\_\_\_\_  
(Summer Start)

EEG \_\_\_\_\_  
(Fall Start )

Radiography \_\_\_\_\_  
(Fall Start)

Respiratory Therapy \_\_\_\_\_  
(Fall Start)

Cardiovascular \_\_\_\_\_  
(Fall Start)

Please Initial the below statement:

**\*\*NOTE:** Prerequisites may only be repeated once to be considered for admittance to the the MRI/EEG/Radiography/Respiratory Therapy/Cardiovascular program

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Southwestern Michigan College Criminal Record Check Consent Form

As a health careers student at Southwestern Michigan College, I understand that it is the policy of the institution to secure criminal conviction history information as part of the screening process for students using the information provided below. **List all states that you have worked or lived in for the past seven years.** NOTE: **A copy of your current driver's license must be submitted with this form.**  
58900 Cherry Grove Road, Dowagiac, Michigan 49047 Phone: 269-782-1236 Fax: 269-782-1239

I understand that the Central Records Division of the Michigan State Police, Lansing, Michigan, requires the above information. I authorize Southwestern Michigan College to utilize the above information for the purpose of obtaining a conviction only crime file search. I understand that if it is discovered that I have a criminal record, it will prohibit my admission to a health careers program.

Date: \_\_\_\_\_

Applicant Print Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_



# Southwestern Michigan College Health Record/ Physician's Form

**TO THE PHYSICIAN:** The applicant has been asked to complete the history on the attached copy. Please review for accuracy. Using the following form please make the necessary examinations. This information will be used in the best interest of the applicant and patient safety. This applicant is being considered for a health occupation; therefore, we are concerned about physical stamina. 58900 Cherry Grove Rd, Dowagiac, MI 49047

Applicant's Name: \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_

### Check Each Item

|                        | Normal | Abnormal | Nature of Abnormality |
|------------------------|--------|----------|-----------------------|
| Skin                   |        |          |                       |
| Head/ Neck/<br>Thyroid |        |          |                       |
| Eyes/Vision            |        |          |                       |
| Ears/Hearing           |        |          |                       |
| Nose/Sinuses/Mouth     |        |          |                       |
| Throat/Nodes           |        |          |                       |
| Chest/Breasts          |        |          |                       |
| Lungs                  |        |          |                       |
| Heart                  |        |          |                       |
| Abdomen                |        |          |                       |
| Extremities/Joints     |        |          |                       |
| Vascular               |        |          |                       |
| Neuro/Reflexes         |        |          |                       |
| Mental Status          |        |          |                       |

Is this applicant subject to any physical limitations? No \_\_\_\_\_ Yes \_\_\_\_\_

Explain, if yes \_\_\_\_\_

Additional comments regarding the applicant's physical and/or mental health?

\_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_



# Southwestern Michigan College Health Record/ Applicant's Form

INSTRUCTIONS TO THE APPLICANT: This form must be completed, signed and returned to The Nursing Office. All information is confidential and should be as complete as possible. This information will be used in the best interest of the applicant and patient safety. 58900 Cherry Grove Rd, Dowagiac, MI 49047

Please PRINT IN INK or TYPE. You should complete this form. Your physician should complete the Physician's form. Please make sure that you and your physician sign in the proper places.

## PART ONE—TO BE COMPLETED BY THE APPLICANT

DATE \_\_\_\_\_

Name \_\_\_\_\_ Sex (M) (F) DOB \_\_\_\_\_

Street \_\_\_\_\_ Student ID # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Current Phone number (hm) \_\_\_\_\_ (wk) \_\_\_\_\_

Current Medications \_\_\_\_\_

Current conditions under MD's Care \_\_\_\_\_

Sensitivities or Allergies \_\_\_\_\_

Physical Impairments \_\_\_\_\_

Do you have a lifting weight restriction-if yes, please explain

HISTORY Have you had: (check each item)

|                          | No | Yes | If Yes, Explain |
|--------------------------|----|-----|-----------------|
| Tuberculosis             |    |     |                 |
| Diabetes                 |    |     |                 |
| Epilepsy                 |    |     |                 |
| Cancer                   |    |     |                 |
| Asthma                   |    |     |                 |
| Heart Disease            |    |     |                 |
| High Blood Pressure      |    |     |                 |
| Eye or Ear Problems      |    |     |                 |
| Shortness of Breath      |    |     |                 |
| Kidney Disease           |    |     |                 |
| Fainting or Dizzy Spells |    |     |                 |
| Color Blindness          |    |     |                 |
| Contact Lenses           |    |     |                 |
| Severe headaches         |    |     |                 |
| Anxiety Reactions        |    |     |                 |

**NEXT PAGE**

**PAGE 2 of Health Record/ Applications Form**

PRINT name of physician who will perform your examination:

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_

To the best of my knowledge, the above information is correct. I understand that misinformation may result in dismissal.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_



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These items will be required after being accepted into the program and will be explained in further detail at orientation.

## **Health Screening and Certifications**

- TB Test (Mantoux-1yr; Skin or QuantiFERON Gold Blood test; Chest X-rays are no longer accepted unless positive skin test).
- CPR Certification

## **Immunization Records**

- MMR (Titers OR 2 vaccine series)
- Tdap (No more than 10 Years old)
- Hepatitis B (Titers or Full series if the series is less than 10 years old)
- Varicella Zoster Vaccine (Titers OR Vaccine Series)
- Covid 19 Vaccination Series or Exemption Form
- Current season flu vaccine (yearly)

(Titers can be done at Ascension Borgess Lee in Dowagiac.)