DIAGNOSTIC MEDICAL SONOGRAPHY APPLICATION

Applications will be accepted until June 1st.

Applications received after June 1st will be considered on a space available basis.

Please contact program staff @ 334-493-5345 or 5389 for any questions.

COPIES OF ALL COLLEGE TRANSCRIPTS MUST BE ATTACHED TO THIS APPLICATION

Date of Application _____ Year Plan to Enter Program Fall Semester (Year)

LBWCC Student No. _____ Social Security No. _____

Name _____

Last First Middle Maiden

Mailing Address _____

City _____ State _____ Zip _____

Email _____

Home Phone _____ Emergency Contact _____

Cell Phone _____ Relationship _____

Work Phone Emergency Contact Phone

Previous Education (Please attach copies of transcripts from all colleges previously attended.)

Transcript Attached	College Name	City/State	Diploma/Degree	Date
☐ Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				

If you are applying to other allied health or nursing program, please list in order or preference for admission:

1 2 3

Have you completed a 2 year allied health patient care related program? ☐Yes☐No Which field: _____

STUDENTS PLEASE COMPLETE WITH THE HIGHEST GRADE ACHIEVED FOR THE FOLLOWING COURSES

Class	Credit Hours	Grade	Comments
ORI 101 Orientation to college	1		
ENG 101 English Composition I	3		
HUM Humanities/Fine Arts Elective	3		
MTH 100 Intermediate College Algebra	3		
BIO 201 Human Anatomy & Physiology I	4		
PHY 112 Principles of Physics	2		
PSY 200 General Psychology	3		

☐Yes☐No Observation Total Hours_____ (4 hours minimum) documentation of hours attached to this application.

☐Yes☐No Copy of ALL college transcripts (unofficial), including LBWCC, attached to this application.

☐Yes☐No ACT Composite Score_____ (19 minimum) -Proof of ACT score must be attached to this application.

☐Yes☐No Signed and dated Handbook Verification Form attached to this application.

☐Yes☐No 3 letters of reference attached to this application.

☐Yes☐No Essay-(1page minimum) "Why I want to be a Sonographer" attached to this application.

Signature: **Date:**

Mail complete application to:

Diagnostic Medical Sonography Program
ATTN: Olivia Bush
Lurleen B. Wallace Community College
P. O. Drawer 910
Opp, Al 36467

For official use only:

Date Application Received:_____ Complete:□Yes □ No

Application Reviewer's Initials:

Additional documentation required: