Peconic Bay Medical Center
Northwell Health

School of Radiologic Technology

PLEASE NOTE! You will not be permitted to sit for the Entrance Exam without this form being completed and submitted FIRST!

Eastern Campus Classroom: 1225 Ostrander Avenue, Riverhead, New York 11901
Western Campus Classroom: 1979 Marcus Avenue, New Hyde Park, New York 11042
Mailing Address: 1300 Roanoke Avenue, Riverhead, New York 11901
(631) 548-6173
E-mail: xrayschool@pbmchealth.org

APPLICATION FOR ADMISSION – DUE MARCH 1, 2024! (CLASS OF 2026)

Part I: Information

Name: _____

Street Address: _____

Town: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Cell Phone #: _____

Social Security #: _____ Application Date: _____

Person To Be Contacted In Case of Emergency: _____

Telephone # of Emergency Contact: _____ Relationship: _____

Have You Ever Been Known By Another Name? _____ YES _____ NO

If Yes, What Was The Name? _____

Are you legally eligible to attend school in the
USA as per the Immigration Reform & Control Act? _____ YES _____ NO

Are you able to perform the duties of a student radiographer as stated in the *Technical Standards* on pages 8 to 11 of the Program Catalog?

_____ YES _____ NO

Are you a graduate with the minimum of an Associate Degree from an accredited college/university?
If not, please state when your degree will be conferred by the college/university?

_____ Date of Conferral _____ YES _____ NO

Have you ever had any previous training in Radiography? _____ YES _____ NO

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Do you have any previous healthcare experience? _____ YES _____ NO
A "No" response does not negate your admission to the school!

What is your current email address? _____
Please PRINT CLEARLY ANY CHARACTERS IN THE EMAIL ADDRESS!
WE WILL CONTACT YOU USING YOUR EMAIL ADDRESS SUPPLIED UPON APPLICATION!

PLEASE INDICATE YOUR PRFERENCE FOR YOUR CAMPUS CLASSROOM AS THERE ARE TWO CLASSROOMS TO SERVE THE MISSION OF THE PROGRAM:
(Please indicate by 1st or 2nd choice!)

Eastern Campus Classroom 1225 Ostrander Avenue, Riverhead, New York 11901		**Western Campus Classroom** 1979 Marcus Avenue, New Hyde Park, New York 11042	

PLEASE READ!!!!
The program cannot GUARANTEE PLACEMENT of your classroom preference. Please understand that you also could be assigned to clinical sites throughout the entire Northwell system regardless of your campus classroom preference. Your Clinical Coordinator will assign your location once you are accepted to the program.
**Reminder, your clinical site rotations are currently scheduled for every three months, but this could change to meet programmatic needs or clinical site needs.*
Example: Eastern Campus Classroom Student "A" could be assigned to North Shore University Hospital/Northwell, Manhasset.
Example: Western Campus Classroom Student "B" could be assigned to Peconic Bay Medical Center/Northwell, Riverhead.

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Part II: Education Section

College/University #1 (Most Recent Please!)

Name of Institution: _____

Address of Institution: _____

Town, State and Zip of Institution: _____

Attended From: _____ Attended To: _____

Degree/Certificate Awarded: _____

College/University #2

Name of Institution: _____

Address of Institution: _____

Town, State and Zip of Institution: _____

Attended From: _____ Attended To: _____

Degree/Certificate Awarded: _____

High School/GED Certificate

Name of Institution: _____

Address of Institution: _____

Town, State and Zip of Institution: _____

Attended From: _____ Attended To: _____

Did you graduate/complete the requirements for the diploma/certificate? _____

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***PLEASE CONTACT **ALL** EDUCATIONAL INSTITUTIONS TO HAVE YOUR OFFICIAL TRANSCRIPTS FORWARDED TO THE FOLLOWING ADDRESS:

Peconic Bay School of Radiologic Technology
1300 Roanoke Avenue, Riverhead, New York 11901
Riverhead, New York 11901
Attention: Frank A. Zaleski, LMSW, MBA, BS RT (R), Program Director

Part III: Employment Section

Employer #1 (Most Recent)

Name of Employer: _____

Address of Employer: _____

Town, State and Zip of Employer: _____

Employed From: _____ Employed To: _____

What Is/Was Your Position? _____

Employer #2

Name of Employer: _____

Address of Employer: _____

Town, State and Zip of Employer: _____

Employed From: _____ Employed To: _____

What Was Your Position? _____

Employer #3

Name of Employer: _____

Address of Employer: _____

Town, State and Zip of Employer: _____

Employed From: _____ Employed To: _____

What Is/Was Your Position? _____

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Part IV: Professional/Academic References *(Please-no relatives or friends!)*

1. Name: _____ Relationship to Person: _____

   Telephone #: _____

2. Name: _____ Relationship to Person: _____

   Telephone #: _____

3. Name: _____ Relationship to Person: _____

   Telephone #: _____

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Part V: Requirements

I have enclosed the essay component of the application utilizing the "**PERSONAL ESSAY FORM ATTACHMENT"** or submitted the essay in the electronic application answering the question: **"Out of all the healthcare professions to choose from, why are you choosing Radiologic Technology at Peconic Bay Program of Radiologic Technology?"**

_____ YES _____ NO

I have enclosed the application fee of **$100.00** made payable to: **"Peconic Bay Medical Center"**

CERTIFIED BANK CHECK _____ _____ YES _____ NO

PLEASE NOTE THAT YOU CANNOT SCHEDULE YOUR ENTRANCE EXAM OR TAKE YOUR ENTRANCE EXAM UNLESS WE HAVE RECEIVED THIS APPLICATION TO THE SCHOOL! THERE ARE NO EXCEPTIONS!

All of the answers given in this application are true and complete to the best of my knowledge. If I am accepted into the Peconic Bay School of Radiologic Technology, I agree to abide by the rules, policies, and regulations set forth by the school and by Peconic Bay Medical Center.

Signature: _____ Date: _____

*A CERTIFIED BANK CHECK is a check that you receive from your bank. **A certified check is a personal check guaranteed by the check writer's bank.** The bank verifies the account holder's signature and that he or she has enough money to pay, then sets aside the check amount for when it's cashed or deposited.*