

**DIAGNOSTIC MEDICAL SONOGRAPHY
TRAINING PROGRAM**

APPLICATION FORM

Form A

(For applicants applying under Prerequisite A)

**SECTION OF DIAGNOSTIC ULTRASOUND
DEPARTMENT OF RADIOLOGY
HEALTH SCIENCES CENTRE**

**Applications are received between
January 1st and February 15th**

**Chris Harrington, RDMS, RDCS, RVT
PROGRAM CO-ORDINATOR**

**Clifford S. Levi, MD, FRCP
MEDICAL DIRECTOR**

**DIAGNOSTIC MEDICAL SONOGRAPHY
TRAINING PROGRAM**

LAST NAME: _____

FIRST NAME: _____

ADDRESS: _____

EMAIL: _____

PHONE: res: () _____

bus: () _____

cell: () _____

ALLIED HEALTH CREDENTIALS (RT, RN, etc):

if RT, indicate if X-ray, nuclear medicine, radiotherapy, laboratory

From which institution did you receive your allied health diploma or degree?

Date of graduation: _____

Have you previously applied to this program? Please circle YES NO

If yes, which year(s)? 1^o _____ 2^o _____ 3^o _____

If you previously applied to this program, did you receive an interview? Please circle YES NO

Prerequisite A

Graduation from a Canadian minimum two-year (24 calendar months) allied health education program that is patient-care related. Examples of allied health occupations which qualify are: X-ray technologist, nuclear medicine technologist, laboratory technologist, respiratory therapist, or registered nurse. Academically, a minimum “B” average is desirable.

CARDIOPULMONARY RESUSCITATION (CPR)

If the student does not have current certification in CPR, it is recommended that the student complete [Family and Friends CPR](#) prior to the start of the program in August.

HEALTH CARE EDUCATION and CERTIFICATION

Which minimum 24 month allied health program or university degree program have you completed? (e.g. X-ray, Nursing, BSc or BA, etc.)

Which month/year did you complete your training program?

Month _____ Year _____

How many years have you worked in the health care profession not including your training period?

EMPLOYMENT HISTORY (most recent position first)

Position/Title: _____

Employer: _____

Dates employed: _____ to _____
(month/year) (month/year)

Reason for leaving: _____

Position/Title: _____

Employer: _____

Dates employed: _____ to _____
(month/year) (month/year)

Reason for leaving: _____

Position/Title: _____

Employer: _____

Dates employed: _____ to _____
(month/year) (month/year)

Reason for leaving: _____

RELEVANT CONTINUING MEDICAL EDUCATION

Have you attended any seminars or taken any continuing education courses relevant to the health care field since graduation? If so, list seminars/courses and provide supporting documentation. You may include courses you are currently enrolled in but have not yet completed, including courses or seminars you plan on taking in the forthcoming months.

1. _____
Name of seminar/course, name of institution, date started/ended
2. _____
Name of seminar/course, name of institution, date started/ended
3. _____
Name of seminar/course, name of institution, date started/ended

ACHIEVEMENTS, AWARDS, or HONOURS

List any achievements/awards or honours you have received since high school graduation (e.g. dean's honours list; winner of an essay competition or clinical research project; advanced certification). You must provide written proof.

1. _____
2. _____
3. _____
4. _____

CURRICULUM VITAE

It is not necessary to provide a traditional CV (curriculum vitae). However, if you have one which is prepared and current, you may submit it with your application.

PERSONAL REFERENCES

You must submit the following three professional references:

1. your immediate supervisor in your present or most recent place of employment
2. clinical instructor or evaluator from previous training program (if within last 5 years. If you trained more than 5 years ago, please provide a second reference from an employer).
3. other relevant professional reference (physician, hospital administrator, department head)

Please list your references on form UTP5.

Three references forms are enclosed with this application.

Fill in your name on the reference form, and give it to your referee for completion. The referee may also provide a traditional letter style reference with the reference form. The referee must send the reference form and letter directly to the program. It is your responsibility to check with your referee and/or the program to ensure the reference has been received prior to the closing date. Each year a percentage of applications are disqualified because of incomplete or late reference submissions.

Should you be unable to fulfil these specific reference requirements, please contact Chris Harrington at 787-4364 at least three (3) weeks in advance of the closing date.

REMEMBER TO MAKE SURE REFEREES SEND THE COMPLETED FORMS DIRECTLY TO OUR OFFICE.

APPLICATION PROCEDURE

Candidates applying for this training program under **Prerequisite A** must submit the following items **on or before February 15th**.

1. A completed Application Form A.
2. Completed and signed forms: UTP1, UTP2, UTP3, UTP4, UTP5, UTP6, UTP7
3. A copy of 24 month allied health diploma
4. Three (3) professional references to be forwarded directly to program by your referees.

All documents, including references and transcripts must be received by February 15th

It is the responsibility of the applicant to ensure that all required documents are received by the application deadline. Incomplete applications will be disqualified and returned to the candidate. **For further information contact Darlene Rogers at (204) 787-7846 or drogers@exchange.hsc.mb.ca**

PERSONAL INTERVIEW

Approximately half the applicants are interviewed. Each application is reviewed independently by six Selection Committee members. Each application is rated and scored. The score from each reviewer is added and a total score for each applicant is determined. The candidates with the highest scores receive an interview. Interviews are usually held in May. Candidates will be informed in April regarding the status of their application and if they are receiving an interview.

The Selection Committee meets in late May or early June to make the final selection. All interviewees will be notified of the result.

FINAL CHECKLIST

Have you....

1. Completely filled out the application form A
2. Completed and signed forms: UTP1, UTP2, UTP3, UTP4, UTP5, UTP6, UTP7
3. Enclosed a copy of your diploma
4. Enclosed an official transcript of marks (not a copy)
5. Submitted the reference forms to three referees

Please do not staple, clip, bind or cover the application pages.

SEND COMPLETED APPLICATION TO:

**APPLICATIONS c/o Darlene Rogers
HSC Ultrasound Training Program
NA547- 700 McDermot Avenue
Winnipeg, MB
R3E 0T2
Fax: 204 787-1811**

HEALTH SCIENCES CENTRE

APPLICANT REFERENCE FORM

To be submitted by referee by **FAX (204) 787-1811**, or **MAIL to:**

References
c/o Chris Harrington
Ultrasound Training Program
NA547- 700 McDermot Avenue
Winnipeg, MB
R3E 0T2
Fax: 204 787-1811
Telephone: (204) 787-7846

APPLICANT'S NAME: _____

This applicant is applying for admission into the **Diagnostic Ultrasound Training Program**. Since the number of qualified applicants far exceeds the number of positions available, we are anxious to select those individuals whose accomplishments, personal attributes and abilities indicate that they have the greatest potential for success in this diagnostic technology. **In addition to this form, if you wish, you may send a more traditional reference letter.** We respectfully request that you complete this form and return it to the Program **before February 15**. References received after this date will not be accepted. We thank you in advance for your co-operation.

REFEREE'S NAME: _____(please print)

REFEREE'S OCCUPATION: _____

WORK PHONE: () _____

HOW ARE YOU PROFESSIONALLY ASSOCIATED WITH THE APPLICANT? (e.g. instructor, academic advisor, supervising physician, etc.)

HOW LONG HAVE YOU KNOWN THE APPLICANT? _____

HOW WELL DO YOU KNOW THE APPLICANT?

VERY WELL [] FAIRLY WELL [] SLIGHTLY []

WHAT WOULD BE YOUR ATTITUDE TOWARD HAVING THIS PERSON IN A RESPONSIBLE POSITION UNDER YOUR DIRECTION? (circle)

- A. Definitely would want him/her
- B. Would be satisfied to have him/her
- C. Would be satisfied but no strong preference over other individuals

Please provide us with a summary of your overall impressions regarding this person and why you feel he/she has the potential to be a good sonographer.

Signature of Referee: _____

Occupation & title: _____ Dated: _____

With a checkmark (✓) on the profile below, please indicate your honest opinion of this applicant.

PROFILE	Excellent	Very Good	Good	Fair	Poor	No basis for judgement
MOTIVATION FOR THE FIELD OF DIAGNOSTIC ULTRASOUND: Knowledge of the scope & demands of diagnostic ultrasound						
COMMUNICATION SKILLS: Clarity of expression; use of English (written/spoken)						
INTERPERSONAL RELATIONS: Ability to get along with others; attitude towards supervision and criticism						
PATIENT MANNERS: Consideration; tact; courtesy towards patients						
RELIABILITY: Dependability, sense of responsibility, promptness, conscientiousness						
SELF-CONFIDENCE: Assuredness, capability to achieve with awareness of own strengths and weaknesses						
ADAPTABILITY: Ability to learn quickly and apply what has been learned						

PLEASE ACCEPT, IN ADVANCE, OUR THANKS FOR YOUR CO-OPERATION

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