

# APPLICATION FOR ADMISSION



## DIAGNOSTIC MEDICAL SONOGRAPHY

**Danville Area Community College**  
**2000 East Main St, Danville, Illinois 61832**  
**Telephone 217-443-3222 – [www.dacc.edu](http://www.dacc.edu)**

**Please Print or Type Application**

**Name:** \_\_\_\_\_ **Application Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**E-mail address:** \_\_\_\_\_

**Social Security or Student ID #:** \_\_\_\_\_

**Have you ever been convicted of a crime? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**If yes, please give a complete explanation on a separate sheet**

**Please check all that apply and give dates of program attendance and program location.  
 Must provide copy of current license/certification and program/college transcripts from institutions  
 other than DACC.**

**Radiologic Sciences**

**Completed at**

**To- From**

Associate Degree

\_\_\_\_\_

Certificate

\_\_\_\_\_

B.S.

\_\_\_\_\_

**Nursing**

Assoc. Degree

\_\_\_\_\_

BSN or Higher

\_\_\_\_\_

**Health Professions Degree**

Respiratory Therapy

\_\_\_\_\_

Medical Laboratory Technology

\_\_\_\_\_

Other (Specify)

\_\_\_\_\_

\_\_\_\_\_

**Bachelor of Science Degree**

Biology

\_\_\_\_\_

Chemistry

\_\_\_\_\_

Physics

\_\_\_\_\_

Other (Specify)

\_\_\_\_\_

\_\_\_\_\_

**I understand that upon being admitted to the program, I must pass a physical examination and a drug screen approved by Danville Area Community College.**

**I understand that any false or misleading statements made by me on this application will prevent my acceptance into the program or may be cause for dismissal if accepted.**

**I understand that the clinical affiliates require background checks, and thus, students must undergo criminal background checks before entering the program. The appropriate form will be sent to me upon acceptance to the program. I also understand that if the results of the background check prevent me from participating at the clinical sites, I will not be able to enter the program.**

**I understand that if I have any questions relative to interpretation of any part of this application, I should contact the Program Director at [217-443-8552](tel:217-443-8552) or [thoward@dacc.edu](mailto:thoward@dacc.edu).**

**Date: \_\_\_\_\_ Signature: \_\_\_\_\_**

**Return to: Tamara L. Howard  
Medical Imaging Director  
Danville Area Community College  
2000 East Main St.  
Danville, Illinois 61832**

**Let us know how you've heard about our program (ex: Social media, Advisors, Friends, DACC classes... etc.) List all:**

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