

# APPLICATION FOR ADMISSION

## PROGRAM

Year of Desired Admission \_\_\_\_\_. For current information on our open admission classes and application deadlines, please visit our online application form <https://reading.towerhealth.org/admissions/application-process/online/>. If you are interested in multiple programs, we strongly encourage you to call the Admissions Office at 484-628-0100 to learn more about our program options and requirements.

Please select your program of interest. If you are interested in multiple programs, we strongly encourage you to call the Office of Admissions at 484-628-0100 to learn more about our program options and requirements.

- Nursing Day (August)  
  Medical Imaging (January)  
  Diagnostic Medical Sonography (January)  
  Surgical Technology (August)  
 Paramedic (August)  
  Offsite Paramedic–Phoenixville Hospital (January)  
  Medical Laboratory Science (July)  
  Phlebotomy (April)  
 EMT (January)  
  EMT (June)  
  EMT (August)

Do you plan to:    Commute    Live in Residence Hall

Are you a former student of Reading Hospital School of Health Sciences seeking readmission?    Yes    No

Are you a Licensed Practical Nurse?    Yes    No

Are you a certified Emergency Medical Technician?    Yes    No

Are you applying to an EMS program and being sponsored by an organization?    Yes    No

If yes, who is the sponsor? Provide name, address, and email. \_\_\_\_\_

## PERSONAL DATA

Citizenship: Please check one

Are you a United States citizen?    Yes    No   If not, do not proceed – call the school at 484-628-0100 for further instruction.

Permanent Resident – A copy of permanent resident card is required to complete your application.

Name of birth country \_\_\_\_\_

Please use your name as it appears on your Social Security card.

If the applicant's name is not correct as shown on the card (for example, because of marriage or divorce) the applicant should request a new card from the Social Security Administration. This is critical for your transcript, financial aid, and eventual licensing processes. The school will continue to use the old name until the applicant shows documentation that the applicant's name has been changed through Social Security Administration.

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Preferred First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Former Name(s): \_\_\_\_\_

Permanent Address: \_\_\_\_\_

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

Temporary Address: \_\_\_\_\_

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

Preferred Phone (\_\_\_\_) \_\_\_\_\_    Home Phone    Mobile Phone

Email: \_\_\_\_\_

Are you at least 16 or under the age of 18?    Yes    No

If under the age of 18, please include contact information of parent(s) or guardian(s).

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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

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

Have you ever been convicted, pled guilty, entered a plea of nolo contendere, been found guilty by a judge or jury, of a felony or misdemeanor, or received probation without a verdict, disposition in lieu of trial, or an Accelerated Rehabilitative Disposition in the disposition of felony charge, in the course of the Commonwealth of Pennsylvania, the United States, or any other state, territory, possession, or country?

Yes    No

### OPTIONAL: What do you consider your ethnic origin?

- African-American (Black)  
  American Indian/Alaskan Native  
  Asian/Pacific Islander  
  Indian (from India)  
 Latino  
  Middle Eastern  
  Multiracial  
  White (non-Hispanic)  
  Unknown

First language, if other than English: \_\_\_\_\_ Language spoken in your home: \_\_\_\_\_

## EDUCATIONAL DATA

High school program pursued:

- College Prep/Academic  
  General  
  Business  
  GED

Are you a home school study student?    Yes    No

Have you been educated outside the United States?    Yes    No    If yes, what country? \_\_\_\_\_

# APPLICATION FOR ADMISSION *cont.*

## LIST ALL HIGH SCHOOLS AND POST-SECONDARY SCHOOLS ATTENDED

**Please note: Attendance at any other institution must be reported prior to and after submitting the application. An applicant's failure to disclose to this school that he or she has taken a course(s) from another institution shall result in the denial or revocation of admission, and dismissal from the school, if matriculated.**

1. Institution Name: \_\_\_\_\_  
Degree: \_\_\_\_\_ Date of Attendance: \_\_\_\_\_

2. Institution Name: \_\_\_\_\_  
Degree: \_\_\_\_\_ Date of Attendance: \_\_\_\_\_

3. Institution Name: \_\_\_\_\_  
Degree: \_\_\_\_\_ Date of Attendance: \_\_\_\_\_

4. Institution Name: \_\_\_\_\_  
Degree: \_\_\_\_\_ Date of Attendance: \_\_\_\_\_

5. Institution Name: \_\_\_\_\_  
Degree: \_\_\_\_\_ Date of Attendance: \_\_\_\_\_

Has disciplinary action ever been taken against you at any of the institutions attended?  Yes  No

### \*MEDICAL LABORATORY SCIENCE APPLICANTS ONLY

I have reviewed the "Essential Functions" (on the website) and have had an opportunity to ask questions about them, and, now, to the best of my ability, understand and can meet those technical abilities and competencies with or without reasonable accommodation.

Include a list of courses you are taking this fall and those that are planned for future semesters on a separate page and submit with the application.

### EMPLOYMENT DATA (List current or most recent employer)

Employer: \_\_\_\_\_  
Position: \_\_\_\_\_

### GENERAL DATA

Volunteer Activities: \_\_\_\_\_  
\_\_\_\_\_

How did you first learn about Reading Hospital School of Health Sciences? \_\_\_\_\_

Do you plan on becoming employed at Tower Health upon graduation?  Yes  No  I don't know

Have you shadowed a healthcare provider? Please describe: \_\_\_\_\_

### SPECIAL CIRCUMSTANCES

Describe any special circumstances which you believe should be considered in connection with this application.

\_\_\_\_\_  
\_\_\_\_\_

### UNDERSTANDING

As an applicant to Reading Hospital School of Health Sciences I signify that I have reviewed the admission policy. Submission of my application indicates my understanding of all academic requirements and technical standards. I further signify that the information given is, to the best of my knowledge, accurate, correct, and including listing all institutions attended. Permission is hereby given to Reading Hospital School of Health Sciences to investigate all pertinent information regarding my application. If accepted, I agree to inform the school of any changes to the information I have provided on the application prior to, and after acceptance into the school. I understand that giving false information or withholding information prior to or after acceptance into the school may make me ineligible for admission or to continue my enrollment at Reading Hospital School of Health Sciences. The school reserves the right to deny admission or readmission or to revoke admission to any applicant if, in the opinion of the school, his/her admission is not in the best interest of the student or the school. I have read and understand the information included in the application. I understand that the \$30 application fee is non-refundable.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature  
(if applicant under 18 years): \_\_\_\_\_ Date: \_\_\_\_\_

After submitting this form, RHSHS may reach out to you by text. You may opt out at any time. **Mail completed form to:** Reading Hospital School of Health Sciences, PO Box 16052, Reading, PA 19612-6052. Thank you!