MOLLOY COLLEGE

Division of Continuing Education and Professional Development

MRI Program

Name_____Home Phone (____)_____

Address _____ Work Phone (____)_____

City _____St. _____Zip _____ E-mail_____

NYS License # _____ARRT#_____

Expiration Date _____Years of Experience _____

Name of Employer _____

Please indicate how you intend to complete the clinical component of the course:

___I will be completing the clinical component at the facility that I am employed with (if this is the case, you do not need to take out separate malpractice insurance or complete the health forms).

___I will be completing the clinical component through a Molloy clinical site (if this is the case you will need to provide malpractice insurance and complete the health forms on the following pages).

Professional Malpractice Policy#_____
Physical exam: _____Date:_____
□ Completed □Scheduled

I certify that all information I have provided in this application is true and complete to the best of my knowledge.

Signature _____ Date: _____

The completed forms can be mailed to: Marc Fischer, MBA, LNMT, RT, CNMY
Continuing Education and Professional Development
Molloy College -PO Box 5002
1000 Hempstead Avenue
Rockville Centre, New York 11571-5002

The forms may also be faxed to 516-323-3560 or scanned and emailed to conted@molloy.edu

Registration Process:

You will be notified of your admission status to the course within 2 weeks of the receipt of your application. If you are accepted into the program you will be required to make a tuition deposit of $1,000 towards the tuition of $2,500 within two weeks of your acceptance. The balance is due two weeks prior to the start of the course. A refund of the deposit will be made only if written notification of withdrawal is made two weeks prior to the start of the program. After this date, deposit will not be returned.

If you have any questions concerning the application or registration process, please call Molloy College Continuing Education and Professional Development at (516)323-3558 or (516) 323-3550.

Payment by Credit Card

Amount Enclosed _____

You may charge my: Visa _____ MasterCard _____

Card # _____ Expiration Date _____

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Participant's Biography

In the space below, please write a brief statement about yourself. We have included some questions that might help you.

- What can you tell us about yourself?
- What are your goals? (Personal or professional)
- Why are you taking this course?
- What will you do when you finish?
- What concerns you most about taking this program?
- What are some of the strengths you bring to this project?

MOLLOY COLLEGE

Continuing Education Department
Checklist

Physical (Please include:)

☐ Yearly physical exam (our form) by MD, Nurse Practitioner or Physician Assistant.

☐ Two step PPD Tuberculin Test (if positive chest x-ray).

☐ DT every ten years Diphtherial/Tetanus

☐ Evidence of Immunization: Measles, Mumps, Rubella, Chicken Pox

☐ Laboratory Print out of Results of Titres for:
- Rubella
- Rubeola
- Varicella
- Mumps

NB Equivocal results will require a repeat testing; values indicating non-immunity will require a vaccine for rubeola and rubella

☐ Waiver Signed

MOLLOY COLLEGE

Department of Continuing Education
Physical Form

Identify (Check one:): Initial Physical _____ Annual Physical _____

Name_____ Home Phone (___) _____

Address _____ Work Phone (___) _____

City _____St. _____Zip _____ E-mail _____

Date Rec'd by Continuing Education _____ Social Security# ____-____-____

Requires Annually: **(Must be done within 30 days of Physical)**
Tuberculin Test (PPD intradermal only) 1. Date _____ Result: _____

2. Date _____ Result: _____

If positive, then a Chest X-Ray Date _____ Result: _____

Required on Initial Physical Only:

*Attach Lab Reports to this Form

Titre	**Value**	**Date**	**Result**	**If Negative,** ***Date Vaccine Administered***
* Rubella	_____	_____	_____	_____
* Varicella	_____	_____	_____	_____
* Rubeola	_____	_____	_____	_____
* Mumps	_____	_____	_____	_____

Polio Tri-Valent Oral Series Date: _____

Diphteria/Tetanus
(DT) Series Date: _____ Booster within ten years date: _____

**Hepatitis B Vaccine: 1. Date _____ 3. Date _____

2. Date _____ Follow-up Titre _____
(Recommended)**

Students are required to be immunized with Hepatitis B Vaccine prior to the beginning of clinical practice or must sign a Declination statement

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Department of Continuing Education

Physical Form

I certify that (print name of student) _____ is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This individual is able to participate in clinical learning experiences as a student of Nursing.

Height:	_____	Weight	_____	B.P.	_____	HCT:	_____
Vision:	_____	Hearing:	_____	HGB:	_____		
U/A	_____	WBC	_____	Diff:	_____	Latex Allergy	_____

Allergies: _____ Provider Signature: _____

Illnesses: _____ Provider Signature: _____

Injuries: _____ Provider Signature: _____

Restriction on Activity: _____ Provider Signature: _____

Medications: _____ Provider Signature: _____

**Disabilities: _____ Provider Signature: _____

** Students with disabilities are considered on an individual basis. Students must be able to meet program objectives.

_____ _____

Name of Physician (Stamp) Physician's Signature

_____

Address Phone

Date: _____

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Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Name (Print) _____

Student Signature _____ Date _____
Address Phone

Date: _____

Department of Continuing Education

Student Waiver of Health Records

I, the undersigned, authorize release of information from my Student Health Record to affiliating clinical agencies.

Please Sign Below:

Student
Signature: _____ Date: _____