APPLICATION FOR ADMISSION

Year of Desired Admission _____

Program:

☐ Nursing ☐ Paramedic ☐ Medical Imaging ☐ Surgical Technology

☐ Day Tract (24 months)

☐ Evening/Weekend Tract (36 months)

Do you plan to: ☐ Commute ☐ Live in Residence Hall

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

Are you a Licensed Practical Nurse? ☐ Yes ☐ No

Are you a certified Emergency Medical Technician? ☐ Yes ☐ No

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 _____

Date of Birth _____ / _____ / _____ Social Security Number _____
Month Day Year

Former Name(s): _____

Permanent Address: _____

City _____ State _____ Zip _____

Temporary Address: _____

City _____ State _____ Zip _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

Cell/Mobile (_____) _____

Email _____

Are you a permanent resident of Berks County, PA? ☐ Yes ☐ No

If no, what is your legal county of residence? _____
County State

If you are under the age of 21: Name and address 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?

☐ Black (non-Hispanic) ☐ Hispanic Latino ☐ White (non-Hispanic) ☐ Asian/Pacific Islander

☐ American Indian/Alaskan Native ☐ Indian (from India) ☐ Multi-Racial ☐ Other

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 CONTINUED

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.

Name of Institution _____
Degree _____ Date of Attendance _____
Name of Institution _____
Degree _____ Date of Attendance _____
Name of Institution _____
Degree _____ Date of Attendance _____
Name of Institution _____
Degree _____ Date of Attendance _____
Has disciplinary action ever been taken against you at any of the institutions attended? ☐ Yes ☐ No

EMPLOYMENT DATA (List current or most recent employer)
Employer _____
Position _____
Address _____
Phone _____
Date of Employment: From _____ To: _____

GENERAL DATA
Volunteer Activities: _____

How did you first learn about Reading Hospital School of Health Sciences? _____
Are you a dependent or an immediate family member of an employee of Reading Health System, or any of its affiliates or subsidiaries? ☐ Yes ☐ No
☐ If Yes, please give name of employee: _____
Do you plan on becoming employed at Reading Health System 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, and correct. 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. Moreover, 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. 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: _____

Mail completed form to: Reading Hospital School of Health Sciences, PO Box 16052, Reading, PA 19612-6052. ***Thank you!***

REFERENCE FORM

I am applying to the following Program:

☐ Nursing ☐ Paramedic Institute

☐ Medical Imaging ☐ Surgical Technology

Please complete the information and mail to the School of Health Sciences' Office of Admissions
PLEASE PRINT OR TYPE.

SECTION I: TO BE COMPLETED BY APPLICANT

Last Name _____ First Name _____ Middle Initial _____

Under the Family Rights and Privacy Act of 1974, students enrolled at Reading Hospital School of Health Sciences have access to their educational records, including letters of recommendation. However, students may waive their right to see letters of recommendation, and, therefore, the letters will be held in confidence. I waive the right to review the reference form.

_____ Date: _____

SECTION II: TO BE COMPLETED BY EVALUATOR

The above-named individual is applying to Reading Hospital School of Health Sciences. Please rank the applicant in the categories below by placing an X in the appropriate box. Please provide a brief statement on the reverse side. Return the form as soon as possible to the School's Office of Admissions. If an applicant has not signed the waiver above, he or she may request to see the letters of recommendation after enrolling in the School of Health Sciences.

Use Reverse Side for Written Statement

	Excellent	Above Average	Average	Marginal	Poor	Unable To Rate
Ability to learn						
Ability to work independently						
Compassion						
Integrity						
Interpersonal skills						
Leadership ability						
Logical/analytical ability						
Oral expression						
Originality, intellectual creativity						
Perseverance toward goals						
Team member						
Tolerance of diversity						
Written expression						

What is your overall recommendation?

☐ Recommend with confidence ☐ Recommend ☐ Recommend with reservations ☐ Do not recommend

How long have you known applicant? _____

What is your relationship to applicant?

☐ Employer ☐ Supervisor ☐ Teacher/Instructor ☐ Counselor ☐ Clergy

Evaluator's Name: _____

Title: _____

Institution/Department: _____

Address: _____

_____

Phone: _____ E-mail: _____

Signature of Evaluator: _____ Date: _____

REFERENCE FORM CONTINUED

Please use this space to comment about the applicant.

Mail to:
Reading Hospital School of Health Sciences
Attn: Office of Admissions
PO Box 16052
Reading, PA 19612-6052

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Perseverance toward goals						
Team member						
Tolerance of diversity						
Written expression						

What is your overall recommendation?

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How long have you known applicant? _____

What is your relationship to applicant?

☐ Employer ☐ Supervisor ☐ Teacher/Instructor ☐ Counselor ☐ Clergy

Evaluator's Name: _____

Title: _____

Institution/Department: _____

Address: _____

_____

Phone: _____ E-mail: _____

Signature of Evaluator: _____ Date: _____

REFERENCE FORM CONTINUED

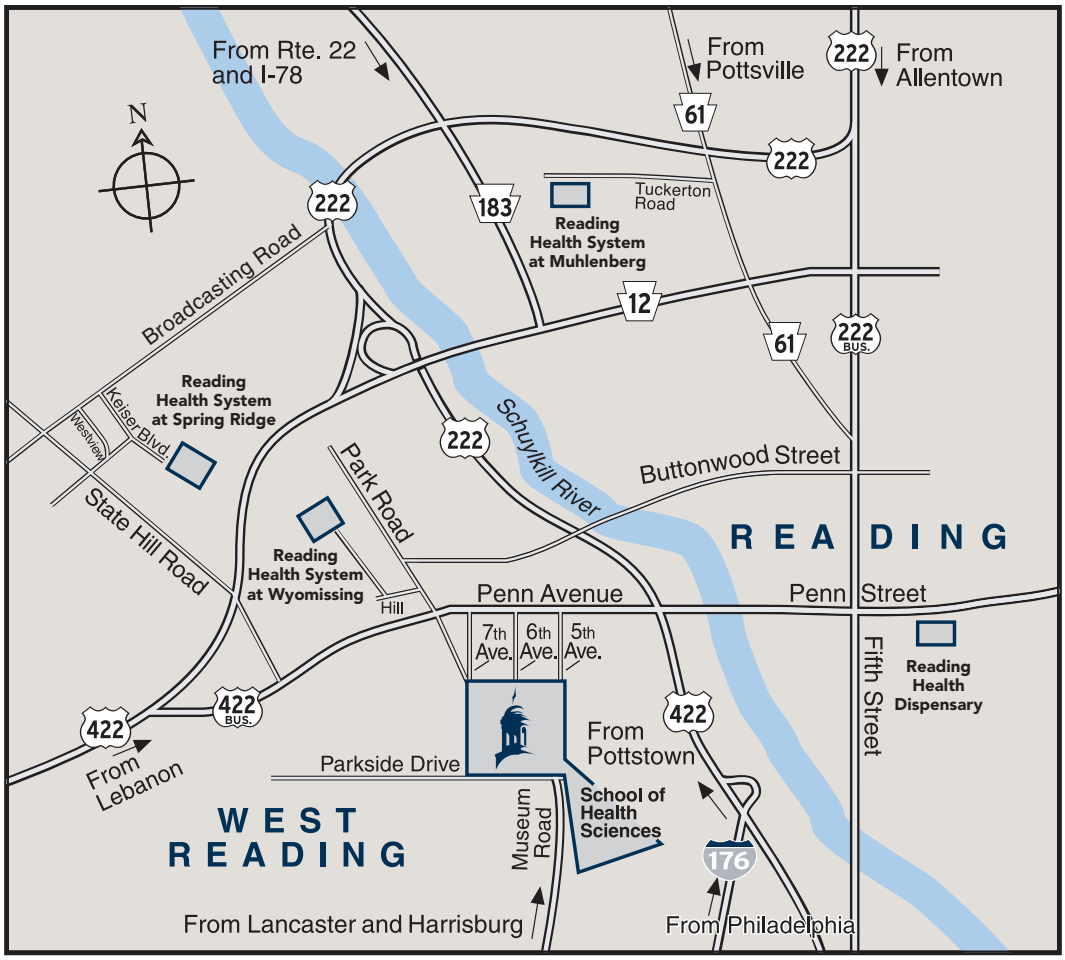
Please use this space to comment about the applicant.

Mail to:
Reading Hospital School of Health Sciences
Attn: Office of Admissions
PO Box 16052
Reading, PA 19612-6052

OUR LOCATION

Reading Health System is headquartered on 36 acres in suburban West Reading, Pennsylvania.

The School of Health Sciences is located on the southeast corner of our West Reading campus. For directions, please visit us on the web at www.readinghealth.org.



CONTACT INFORMATION

Reading Hospital School of Health Sciences reserves the right to make necessary changes to the Programs, curriculum, costs, policies, procedures, and calendar. The School reserves the right to clarify any information printed on the website or in official school publications.

For more information, please contact:
Reading Hospital School of Health Sciences
Attn: Office of Admissions
PO Box 16052
Reading, PA 19612-6052
Phone: 484-628-0100
Email: RHSHS@readinghealth.org

For more information on School policies and annual campus crime report please log onto: www.readinghealth.org/sohs/policies.

Gainful Employment Disclosure information can be found at www.readinghealth.org/sohs/disclosure.

READING HOSPITAL

READING HEALTH SYSTEM

School of Health Sciences

484-628-0100

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