Radiologic Technology Program

This program provides the didactic and clinical content required to prepare graduates to apply to write the American Registry of Technologists (AART) Examination for Radiographers. The curriculum includes instruction in the art and science of using radiation to provide images of tissues, bones, and blood vessels of the human body. Upon successful completion of the examination, graduates are certified as Registered Radiographic Technologist, RT (ARRT) (R).

Application Procedure Deadline: Second Friday in April.

Classes are admitted annually in August. Class size is limited and all applicants are not accepted for participation.

Applications are currently being accepted. Admission into the program will continue until all available slots are filled.

ADMISSION REQUIREMENTS:
1. Completion of all general admission procedures of the College
2. Completion of the Nursing and Allied Health Application for Admission prior to the application deadline.
3. Complete the required general education courses from an accredited college or university with a grade of “C” or above.
4. Compass scores of Reading 83+, Writing 80+ and Math 41+; or minimum ACT score of 19 in each section; or completion of 15 semester hours of general education applicable to the program with a cumulative GPA of 2.5 or higher.
5. Completion or test score validated exemption of all required developmental studies courses in English, Mathematics, and Reading.
6. A minimum 2.5 cumulative grade point average for all college coursework (excluding development courses).
7. Complete a professional observation.
8. Based on the above criteria, the top 30 applicants will be interviewed.

The above information must be submitted to:

Southeast Arkansas College
Division of Nursing & Allied Health Technologies
Attn: Radiologic Technology Program
1900 Hazel Street
Pine Bluff AR  71603

ACCEPTANCE PROCEDURE: Should the number of qualified applicants exceed the available slots in the program, admission into a particular class will be prioritized according to established criteria.

After notification of acceptance into the program, the applicant must provide the following:

1. P.P.D. SKIN TEST OR CHEST X-RAY
2. DOCUMENTATION OF HEPATITIS B SERIES OR SIGNED SOUTHEAST ARKANSAS COLLEGE VACCINATION WAIVER CLAIM FORM
3. FUNCTIONAL ACKNOWLEDGEMENT FORM
4. CRIMINAL BACKGROUND CHECK

Students enrolled in Allied Health Programs with a clinical component will be assessed a fee for malpractice insurance.

Note: Random drug screening may be used anytime during the program at the student’s expense.

4/14
Southeast Arkansas College
Radiologic Technology Program
Mission Statement

The Southeast Arkansas College Radiologic Technology Program seeks to develop leaders in radiologic science workforce by fostering an environment of academic and clinical excellence. Specifically, the mission of the program is to produce well-educated, fully competent, and highly motivated radiologic science professionals who will safely perform diagnostic imaging procedures.

Radiologic Technology Curriculum

Pre-admission Requirements

<table>
<thead>
<tr>
<th>Course</th>
<th>Hours</th>
<th>LEC</th>
<th>LAB</th>
<th>SWE</th>
<th>SCH</th>
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<tbody>
<tr>
<td>BIOL 2454 Anatomy &amp; Physiology I</td>
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<tr>
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Professional Curriculum

1st Year – 1st Semester

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1st Year – 2nd Semester

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Extended Summer Term – 8 weeks

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2nd Year – 1st Semester

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2nd Year – 2nd Semester

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Extended Summer Term – 8 weeks

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Completion award: Associate of Applied Science Degree 79hrs

The program is accredited by the Joint Review Committee on Education in Radiologic Technology (JRCERT), 20 North Wacker Drive, Suite 2850; Chicago, Illinois 60606-2901; (312)-704-5300; www.jrcert.org
SeArk College is accredited by the Commission on Institution of Higher Education of the North Central Association of Colleges and Schools.
SOUTHEAST ARKANSAS COLLEGE
NURSING & ALLIED HEALTH APPLICATION

NAME ______________________________________________________  
DATE OF BIRTH ______________________ SEX: MALE / FEMALE (CIRCLE ONE)  
ADDRESS ________________________________________________________________________________________  
CITY, ZIP CODE ________________________________________________________________  
STUDENT ID# ___________________________________________________________________________________  
PHONE NUMBER _________________________________________________________________________________

PERSONS TO NOTIFY IN CASE OF EMERGENCY

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
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<th>PHONE NO.</th>
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PREVIOUS WORK EXPERIENCE (LIST MOST RECENT FIRST)

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<th>EMPLOYER</th>
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EDUCATION: HIGHEST GRADE COMPLETED

PREVIOUS COLLEGES/UNIVERSITIES ATTENDED: (ALL TRANSCRIPTS REQUIRED ON CAMPUS AT APPLICATION DEADLINE).

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>CITY/STATE</th>
<th>MAJOR DECLARED (IF ANY)</th>
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NAME & ADDRESS OF LAST SCHOOL ATTENDED _____________________________________________________________________________________________________

DATE OF H.S. GRADUATION OR GED _____________________________________________________________________________________________________________

*HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES ___ NO ___ IF SO, PLEASE EXPLAIN: ____________________________

ARE YOU REQUESTING RE-ADMISSION TO ANY SOUTHEAST ARKANSAS COLLEGE NAH PROGRAM? YES _____ NO _____  
IF SO, PLEASE EXPLAIN: ____________________________

DESCRIBE ANY EXPERIENCE IN NURSING OR ANY OTHER FIELD RELATED TO MEDICINE:

__________________________________________________________

__________________________________________________________

ARE YOU WILLING TO TRAVEL TO ANY AGENCY IN OUR SERVICE AREA FOR YOUR CLINICAL TRAINING?  THIS COULD BE UP TO 60 MILES FROM THE INSTITUTION.  YES _____ NO _____  
REASONS: ________________________________________________________________________________________________

PLANS AFTER GRADUATION: ________________________________________________________________________________________________

I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY MISREPRESENTATIONS, FALSIFICATIONS, OR OMISSIONS OF INFORMATION OR ANY ATTEMPT TO DECEIVE SEARK COLLEGE IS CAUSE FOR EITHER DENIAL OR SELECTION FOR ENTRY OR DISMISSAL FROM ENROLLMENT. I AUTHORIZE THE COLLEGE TO RELEASE INFORMATION PROVIDED BY ME IN THE APPLICATION FOR ADMISSION TO THE NAH PROGRAM, TO APPROVAL/ACREDITING AGENCIES, CLINICAL AFFILIATES, AND AS REQUIRED FOR CRIMINAL BACKGROUND CHECKS. THIS AUTHORIZATION ALSO INCLUDED THE RELEASE OF MY TRANSCRIPT.

DATE ___________  SIGNATURE ____________________________

INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN CRIMES MAY BE INELIGIBLE TO WRITE FOR THE AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS (ARRT) AND ALSO MAY BE INELIGIBLE FOR ARKANSAS STATE LICENSE. A CRIMINAL BACKGROUND CHECK WILL BE REQUIRED BY THE ARKANSAS STATE BOARD OF HEALTH PRIOR TO LICENSURE.

4/14
Southeast Arkansas College
Radiologic Technology Program
Professional Observation Verification Form

As part of the application process, it is required that the applicant completes a supervised observation in a radiology department for a period of at least 4 hours. This may be scheduled by calling the Radiologic Technology Program at Southeast Arkansas College 870.543.5941. Please dress in a professional manner. (no shorts or jeans)

During the observation, the applicant is expected to observe general radiography and fluoroscopic procedures. As a guide, the applicant should observe at least four of the following six suggested procedures in order to satisfy the observation requirement.

Please place a checkmark by the procedures that the applicant observed while in your radiology/imaging department. Other procedures not included on this list should also be documented.

_____ Chest  _____ Abdomen  _____ Extremity
_____ IVP  _____ BE  _____ UGI

_____ Other exams not listed ________________________________
______________________________
______________________________

This is to verify that __________________________ spent a total of ________ hours in observation and discussion of the professional obligations and responsibilities of a Radiologic Technologist on __________.  
(applicant’s name)  (min. 4)  (institution where observation occurred)

(date)

Signature  ________________________________

Title  ________________________________

Date  ____________

NOTE: the radiographer who conducted the observation MUST fill out this form. Do not return this form to the applicant. Upon completing both sides of this form, place in the clinical forms box at JRMC or DIC.
Please Complete Back of Form Also
Our desire is to provide graduates with the professional attributes that you would expect from your health care employees. Your input can help us identify the strengths and weaknesses of this applicant based on how they responded during an observation period. Please respond to this evaluation promptly in order to help expedite the selection process.

Was this individual prompt and arrive when scheduled?

_____ YES

_____ NO; please explain:  

Was this individual attentive?

_____ YES

_____ NO; please explain:  

Did this individual ask relevant questions?

_____ YES

_____ NO; please explain:  

Did this individual communicate in a manner consistent with your professional expectations for employment?

_____ YES

_____ NO; please explain:  

Did this individual interact well with other staff?

_____ YES

_____ NO; please explain:  

Did this individual behave in a mature, confident manner?

_____ YES

_____ NO; please explain:  

Is this individual the type of person you would consider for employment?

_____ YES

_____ NO; please explain:  

Any additional comments may be made in the space below:
JEFFERSON HOSPITAL ASSOCIATION, INC.
CONFIDENTIALITY AGREEMENT

Jefferson Hospital Association has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of all patient information.

I recognize and acknowledge that I may have direct or indirect access to patient medical records, computer-stored patient information, or information acquired during the discussion or provision of patient care or hospital support services.

I recognize and acknowledge the release of any information regarding patient care condition and/or services can only be made with authorization of the patient, his/her legal guardian or healthcare proxy. I will not discuss patient information within the hospital, unless required in the performance of my duties and responsibilities, and I will not discuss any patient information outside of the hospital. I also recognize that retrieval of patient information that is not required is forbidden.

I further recognize and acknowledge that I may have Information Systems access that demands my confidentiality. I agree that I will not at any time disclose any such information to any person. I understand that disclosure of such information may give rise to irreparable injury to the healthcare facility or to the owner of such information.

I will not give information to newspapers, magazines, photographers, and radio or television station representatives. I understand that information will only be given by authorized personnel in accordance with approved JHA press relations.

I have read and do understand the above requirements of the JHA Confidentiality Agreement. I further understand that any violation of this agreement, whether inadvertent or intentional, may be considered a violation of the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules.

Name (printed clearly) & SS# Company Name; Job Title

Signature Date

Same privileges as (user in same role)

Approval signature (manager)