ST. MARY'S CENTER FOR EDUCATION
SCHOOL OF MEDICAL IMAGING
SONOGRAPHY PROGRAM APPLICATION

*please print legibly

Applicant name: _____
(last name, first name)

Academic year and semester you are applying for:_____

St. Mary's SOMI graduate _____yes _____no If yes, year_____

Other radiology program graduate: _____

Desired Sonography Specialty: _____

Contact Information:

Email address: _____

Phone number (LAN or CELL please indicate) _____ _____
Area code number

Home Address:_____ _____
Street apt #

City:_____ State_____ Zip Code: _____

If you are a student of St. Mary's SOMI please give the admissions office or Program Director permission to forward a copy of your Medical Imaging and MU transcripts to the Sonography Office upon request.
Any questions please contact:
Nancy MacClellan, MS, RDMS, RDCS,RVT
Program Director/Adult Echo Clinical Coordinator
Diagnostic Medical Sonography Program
304-526-1430
nancy.macclellan@st-marys.org

Staff Use ONLY
SOMI GPA: _____ Date: _____
MU GPA: _____ Accepted____ Denied _____
Signature: _____

Reviewed 10/2020