Chaffey College
Health and Wellness

Radiologic Technology Acute Care Hospital Work Experience
Application for Additional Point

RT Applicant Name:_____ Chaffey College Student ID#: _____

Instructions:

1. Applicants are to complete Part I of this form, print, and ask their employer/volunteer verifier to complete Part II.
2. *Note: All signatures **MUST** be official "wet" signatures (signed original copy). Electronic signatures will not be accepted.
3. Once this form is completed in its entirety, applicant will upload the form to the RT application.
4. *Students must submit all required documentation for an additional point in one attempt. If documentation is incomplete, materials may not be resubmitted.

Part I (to be completed by applicant)

I have at least 500 hours of acute care hospital experience that meets the following criteria.

Consideration for one additional point will be given to applicants with prior ***acute care hospital**** work experience **with documentation of 500 hours** of general hospital experience **with *medical direct patient care*** within the last 5 years.** Examples of medical direct patient care are: RT transporter, CT or MRI assistant, CNA, MA, LVN or phlebotomist. ***DOCUMENTATION OF THIS WORK EXPERIENCE MUST BE SUBMITTED WITH THE RT APPLICATION (UPLOADED ALONG WITH THIS FORM). EXAMPLES OF ACCEPTABLE DOCUMENTATION INCLUDE BUT ARE NOT LIMITED TO A RECENT PAYCHECK STUB, RECENT TIMESHEET PRINTOUT, HR PRINTOUT DOCUMENTING HOURS, SIGNED ATTESTATION FROM HR OF NUMBER OF HOURS WORKED/VOLUNTEERED.*** The point for experience is not guaranteed until verified by the Program Director.

**Acute care hospital must have an emergency room, ICU, and surgical departments*

***Medical direct patient care is the healthcare services of a patient provided personally ("hands-on" actually touching patients). **Examples not qualifying are:** clerical, reception, environmental services.*

Part II (must be completed by employer/volunteer verifier)

All signatures **MUST** be official "wet" signatures (signed original copy). Electronic signatures will not be accepted.

- Title of employee/volunteer or in what capacity they worked: _____
  _____
  _____
- Name of the acute care hospital: _____
- Dates of employment/volunteer service: _____
- Estimated total hours to present day: _____

All the information provided is correct to the best of my knowledge.

Date: _____

Employer/Verifier (Print Name:) _____

Employer/Verifier Wet Signature:_____

Title: _____

Phone number:_____Email:_____

The RT Application Verification Committee will make the final determination of acceptance of work or volunteer experience. *Students must submit all required documentation for an additional point in one attempt. If documentation is incomplete, materials may not be resubmitted.

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