Dear Healthcare Provider,

____________________________________, an applicant of the Lone Star College-Montgomery Radiologic Technology Program, has declared that he/she has either been employed or has been a volunteer at your institution. Since we value our prospective students’ medical imaging experiences and their additional insight into the profession, they have the opportunity to receive additional consideration in our program’s admission process.

In order for our program to recognize the applicant’s experience, we require verification of the above referenced individual’s work/volunteer/observation experience while under your supervision. Please provide a response to all information requested on the Healthcare Experience Verification Form. **All information must be submitted no later than October 9, 2015, in order for the applicant’s information to be considered in the selection process.** Following completion of the form, it should be directly mailed to the Radiology Technology Program at the address listed below. Please place your signature across the seal of the envelope to ensure authenticity if the student intends on hand delivery to the college.

LONE STAR COLLEGE-MONTGOMERY  
Division of Natural Sciences & Health Professions  
Attn: Radiologic Technology Program  
3200 College Park Drive  
Building B, Suite B-120  
Conroe, Texas 77384-4077  
936-273-7012

Thank you for taking the time to complete this form, and please feel free to contact me if you have further questions regarding this request.

Sincerely,

\[Signature\]

Dr. Francis C. Ozor, Ed. D., RT(R)  
Director, Medical Radiologic Technology Program  
Lone Star College-Montgomery  
3200 College Park Drive  
Conroe, Texas 77384  
936-273-7412  
fcozor@lonestar.edu
RADIOLOGY TECHNOLOGY PROGRAM

MEDICAL IMAGING EXPERIENCE VERIFICATION FORM

Applicant Name: ____________________________________________

Check One:

Employee _____
Volunteer _____

Actual Date of Employment/Volunteer/Observation:
From _______/_____/_____
To _______/_____/_____

Hours per Week (if employment): ____________
Total Hours (if volunteer/observation experience): ____________

Type of Work/Duties Performed:
________________________________________________________________
________________________________________________________________

Name and Title of Contact Person Completing Form:
________________________________________________________________
________________________________________________________________

Healthcare Institution:
________________________________________________________________
________________________________________________________________

Contact Person Completing Form:
________________________________________________________________
________________________________________________________________

Phone Number: (_______)_______-____________

Signature of Supervisor/Representative:
________________________________________________________________
________________________________________________________________

Date: ____________

NOTE FOR SUPERVISOR/REPRESENTATIVE:

(Contract Person Completing Form)

Date: __________________

Signature of Supervisor/Representative: ______________________

Phone Number: ____________________________

Address: __________________________________________________________________

Care Health Institution: ____________________________

Name and Title of Contact Person Completing Form: ____________________________

Type of Work/Duties Performed:

From: ____________
To: ____________

Actual Date of Employment/Volunteer/Observation:

Employee Volunteer Check One: Employment Volunteer

Appliant Name: ____________________________________________