LONE STAR COLLEGE-CYFAIR RADIOLOGIC TECHNOLOGY PROGRAM

Dear Healthcare Provider,

______________________________ an applicant of the Lone Star College-CyFair Medical Radiologic Technology Program; has declared that he/she has either been employed or has been a volunteer or has been an observer at your institution.

Since we value our prospective students' healthcare experiences and their additional insight into the profession, they can 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 experience/observation, while under your supervision. Please provide a response to all information requested on the Healthcare Experience Verification Form. If additional space is required, please include a separate document along with the completed second page of this form.

Supervisors or facility representatives must submit all necessary forms by email to:
Lawrence.E.Norris@LoneStar.edu
And give a copy to the student so they can upload during the application period.
Thank you for taking the time to complete this form and email it to me, please feel free to contact me if you have further questions regarding this request.

Sincerely,

Lawrence E. Norris Jr.
Program Director, Medical Radiologic Technology Program
Health Sciences Center II / 250 K
9191 Barker Cypress Road
Cypress, Texas 77433-1383
Lawrence.E.Norris@LoneStar.edu
281.290.3926

Medical Radiologic Technology Program
Healthcare Experience Verification Form

Applicant Name:____

Circle One: Employee/Student Volunteer Observer

Actual Dates of Employment, Volunteer, or Observation:

Start Date: ____________________

End Date: _____________________

Hours per Week: _______________

Type of Work/Duties Performed:

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I hereby certify that the information contained in this form is true, complete to the best of my knowledge. I understand that any omission, misrepresentation or falsification of information is cause for denial of admission or immediate dismissal from the MRI program.

Healthcare Institution Information:

Facility Name: ____

Address City, State, Zip____

Contact Phone ____________________

Supervisor or Representative completing form:

Printed Name & Title____

Signature____ Date ___________________