

**PARTNERS RADIOLOGY  
MEDICAL IMAGING PROGRAM  
LOAN FORGIVENESS APPLICATION**

**PERSONAL INFORMATION**

Name \_\_\_\_\_  
Last First MI

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address 1 \_\_\_\_\_

Email Address 2 \_\_\_\_\_

Preferred method of contact (Please circle one):

Email 1      Email 2      Home Phone      Work Phone      Cell Phone

Social Security # \_\_\_\_\_ Partners Employee: Y \_\_\_\_\_ N \_\_\_\_\_

**EDUCATION**

High School \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Diploma / Equivalency Degree \_\_\_\_ Yes \_\_\_\_ No

College \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Diploma / Degree \_\_\_\_ Yes \_\_\_\_ No Major \_\_\_\_\_

College \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Diploma / Degree \_\_\_\_ Yes \_\_\_\_ No Major \_\_\_\_\_

Other School(s) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Diploma / Degree \_\_\_\_ Yes \_\_\_\_ No Major \_\_\_\_\_

**WORK HISTORY** (List most recent information)

Partners HealthCare System Employees must fill out the following information

**Employer** \_\_\_\_\_ Dates \_\_\_\_\_  
Name From/To

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Position \_\_\_\_\_

Department \_\_\_\_\_ Supervisor \_\_\_\_\_

**Employer** \_\_\_\_\_ Dates \_\_\_\_\_  
Name From/To

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Employer** \_\_\_\_\_ Dates \_\_\_\_\_  
Name From/To

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Employer** \_\_\_\_\_ Dates \_\_\_\_\_  
Name From/To

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Have you collected Unemployment Compensation in the last year?**

Y \_\_\_ N \_\_\_ If "yes", please provide dates unemployment compensation was collected:

From/To \_\_\_\_\_

## RADIOLOGIC TECHNOLOGIST PROGRAM INFORMATION

School Name: \_\_\_\_\_

School Address: \_\_\_\_\_

Have you applied and/or been accepted into the program? \_\_\_\_ Yes \_\_\_\_ No

When does the program begin? \_\_\_\_\_

When do you expect to complete the program? \_\_\_\_\_

Type of program: RT    Ultrasound    Nuclear Medicine    Other \_\_\_\_\_

## FINANCIAL INFORMATION

What is the tuition cost for each semester? \_\_\_\_\_

(Please attach tuition cost information from school's catalogue)

Are you seeking **scholarship support** for \_\_\_\_ one year \_\_\_\_ two years?

Have you applied for financial aid through other sources? (Please explain)

\_\_\_\_\_

## PERSONAL REFERENCES

List three (3) personal references that we have your permission to contact on your behalf.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**How did you hear about this loan forgiveness program? (Please check one)**

Career Center	Guidance Counselor	Television
Coworker	Human Resources	Radio
College Faculty	Internal Partners email announcement	Web Search
Career Newsletter	Newspaper	Other
Friend	Supervisor	_____

## **PERSONAL STATEMENT OF ACADEMIC AND CAREER GOALS**

Please describe in essay form why you are applying to the scholarship program. Please include a description of your career and educational objectives, related experiences, your perceived strengths and weaknesses, and which qualities you might bring to Partners HealthCare System and to the larger world of allied health and medical professions.

(Please submit the above essay in a MS Word document)

I certify that my responses to the above questions are true. I understand falsification of any of the above facts or other information supplied by me is grounds for denying my scholarship application from further review and consideration or discontinuation of a scholarship (including immediate return of any funds provided).

Your signature \_\_\_\_\_ Date \_\_\_\_\_

### **SCHOLARSHIP APPLICATION CHECK LIST**

\_\_\_\_ 3 Letters of Recommendation from Supervisors/Instructors/ Guidance Counselors

1) \_\_\_\_ 2) \_\_\_\_ 3) \_\_\_\_

\_\_\_\_ Letter of acceptance into Radiology Imaging Program

\_\_\_\_ Application

\_\_\_\_ Personal Statement

## **RECOMMENDATION FORM**

**Please describe how the applicant has demonstrated his or her potential to complete a college-level training program in the medical imaging sciences, and which personal qualities they might bring to patients, staff, and colleagues in the Departments of Radiology at Partners HealthCare System. Thank you.**

*Voluntary Affirmative Action Information Completion of the Information Below is  
Voluntary*

**AN EQUAL OPPORTUNITY EMPLOYER**

The following information is required for various record keeping purposes in connection with Federal Government reporting requirements and the Affirmative Action Program. Please be advised that the information on this form is not part of your official application for the Partners HealthCare System Medical Imaging Scholarship Program. It is considered confidential and will not be used in any scholarship award decisions.

Sex \_\_\_\_M \_\_\_\_F

**RACIAL/ETHNIC CLASSIFICATION-PLEASE CHECK ONE OF THE FOLLOWING:**

Black (Not of Hispanic origin): A Person having origins in any of the Black racial groups of Africa.

Asian or Pacific Islander: A Person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands.

American Indian or Alaskan Native: A Person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.

Hispanic: A Person of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin, regardless of race.

White (Not of Hispanic origin): A Person not classified into one of the four specific categories above; also includes, by definition, persons having origins in any of the original people of Europe, North Africa or the Middle East.

**Special Notice to Vietnam era veterans, disabled veterans and individuals with physical or mental handicaps or disabilities:**

Government contractors subject to the Vietnam Era Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 are required to take affirmative action to employ and advance in employment qualified disabled veterans and veterans of the Vietnam era, and qualified handicapped individuals.

Veteran Status  Disabled Veteran  Handicap

This information will be considered confidential, and refusal to provide this information will not adversely affect your consideration for the Baccalaureate Completion Scholarship Program or, if applicable, any other aspect of your employment or consideration for employment.

*This form to be filed separately from the application.*