

**THE IMAGING NETWORK
DIAGNOSTIC ULTRASOUND PROGRAM APPLICATION**

I. APPLICANT INFORMATION

DATE _____

Name _____ Sex _____ D.O.B. _____ Age _____

Address _____ SS# _____

City _____ State _____ Zip _____

Work Phone _____ Home Phone _____

Fax _____ E-Mail _____

Highest Degree Earned _____

Prior Ultrasound Experience Yes No How Much? _____

Observation Only Hands-on? Explain _____

Are you interested in sharing hotel and car rental expenses with another applicant?

Yes No Explain _____

Are you willing to be a model for OB/GYN students to perform ultrasounds?

Yes No Are you pregnant? Yes No

II. PREGNANCY CARE CENTER OR ORGANIZATION INFORMATION

Name of PCC/Organization _____ Director _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-Mail _____

III. PLEASE INDICATE WHICH LOCATION & DATE YOU WISH TO ATTEND

LOCATION _____

DATE: _____ 5 DAYS 3 DAYS

IV. EMERGENCY CONTACT (2 names needed)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Name _____ Relationship _____

Home Phone _____ Work Phone _____

V. ULTRASOUND INFORMATION

Is your PCC a medical facility? Yes No

Are you considering converting to one? Yes No If yes, when? _____

Names and Degrees of Medical Personnel on your staff:

List all services your PCC offers:

Do you desire to use ultrasound? Yes No

Do you desire to refer out for the ultrasound service? Yes No

Do you wish to provide service in your PCC? Yes No

Please supply complete information regarding your goals with respect to ultrasound and your PCC:

Do you have a sonographer available to assist in providing ultrasound? Yes No

If no, do you have a licensed nurse willing to be trained? Yes No

If you currently own/lease an ultrasound machine, please indicate kind, year, and model

Are you satisfied with the quality of the image? Yes No

Explain _____

Are you seeking to purchase a new or used ultrasound system? Yes No

Do you desire SWI to refer an ultrasound sales representative to you? Yes No

Are you interested in more information on *The Imaging Network Diagnostic Ultrasound Manual* or future workshops? Yes No Explain _____

MEDICAL AND/OR PARAMEDICAL EDUCATION

Name of Institute _____

Address _____

Dates Attended _____ Degree (if any) _____ Major _____

X-ray Registry # _____

Was this program college based, hospital based, other _____

Are you registered in your field? Yes No If so, when _____

Are you registered in more than one field? Yes No Is so, list below _____

UNDERGRADUATE OR JUNIOR COLLEGE

Name of Institute _____

Address _____

Dates Attended _____ Degree (if any) _____ Major _____

CURRENT STATUS

Still in School Graduation Date _____ Working

Name of Institute _____

Length of Employment _____ Your Position _____

Immediate Supervisor _____

ADDITIONAL INFORMATION REQUIRED

- Certificate of graduation from paramedical education (all students)
- Copy of registration in your field(s) (all students)
- Recent photograph for identification purposes (all students)

Enclosed is my **check payable to Sound Wave Images, Inc. for \$** _____.

Please charge \$ _____ to my MasterCard VISA

Account # _____ Exp. Date _____

Signature _____