THE CURE CENTER
FOR ULTRASOUND RESEARCH & EDUCATION

1-855-843-2873
info@cure.edu
www.cure.edu

APPLICATION FOR ADMISSION

DATE OF APPLICATION

APPLICATION DATES AND DEADLINES

CURE recommends that applicants submit admission materials at least one month prior to the quarter start date in order to be considered for acceptance into the student's program of choice. Applications will be accepted if received in the Admission's office if postmarked by the dates listed below.

There are no deadlines to apply to CURE. CURE has ongoing enrollment for our annual class start.

REQUIRED APPLICATION MATERIALS

1) Completed Online Application
2) Completed Written Application
3) Official High School and College Transcripts
4) Verification of 30 hours of hospital internship/volunteer work or equivalent medical experience documentation.
5) Pre-Requisite Courses Completed at a College or Trade School Level or Verification of Registration for CURE Pre-Requisite Courses including Anatomy & Physiology, Mathematics, Physics and Communications.
6) Immunization Records including MMR, Hepatitis B, Tuberculosis Skin Test, Meningococcal Declination Form or verification of Meningococcal Vaccine as required by CURE and NYSDOH.
7) Statement of Good Physical Health from Physician within 12 months from time of enrollment.
8) Negative Toxicology Screening
9) Registration Fee
10) Signed Enrollment Agreement

APPLICANT INFORMATION

Social Security Number _____ **Date of Birth** _____

Full Name _____

Last **First** **Middle**

Former Name(s) _____

Address _____

Street and Number **Apt. No.**

City _____ **State** **Zip** _____

Daytime Phone _____ **Alternate Phone** _____

E-mail address _____

REQUIRED PRE-REQUISITES

Please check the courses you have completed at a college-level with a grade of "C" or better.

□ Anatomy and Physiology
□ Algebra, Statistics or Higher Math
□ English Composition, Speech or Communications
□ General Physics
□ Other

EDUCATION

Please check the education you have achieved.

□ MD, PhD
□ Master's Degree
□ Bachelor's Degree
□ Associate's Degree
□ High School Graduate
□ GED

School Name and Address: _____

Year of Graduation: _____

Please list all education, including any previous sonography coursework.
(*Please be sure to include official transcripts with the application in an envelope sealed by the indicated College or University.)*

Institution	**Dates Attended**	**Degree(s) Awarded**
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If additional space is needed, please attach a separate sheet of paper.

WORK EXPERIENCE

Please list all employers and job responsibilities for the past 10 years.
(A personal resume may be submitted as a substitute for this section of the application form.)

Job Title _____ **Dates of Employment** _____

Employer _____

Primary Responsibilities _____

Job Title _____ **Dates of Employment** _____

Employer _____

Primary Responsibilities _____

Job Title _____ **Dates of Employment** _____

Employer _____

Primary Responsibilities _____

If additional space is needed, please attach a separate sheet of paper or resume.

PROFESSIONAL LICENSE

Professional Licensure(s)/Credential(s) (A copy of most current card(s) must be submitted):

_____

License **Credential Identification Number**

_____

License **Credential Identification Number**

HONORS/AWARDS

Please list any honors/awards you have received.

EXTRACURRICULAR ACTIVITIES

Please list any extracurricular activities you are or have been involved in.

ADDITIONAL INFORMATION

Please provide any additional information you feel is pertinent to this application.

REFERENCES

It is recommended that each applicant provide three (3) references. Two (2) references should be from educational and/or work experiences. The third may be anyone, other than a family member, who has known the applicant for at least one year.

If you do not have the required references, this will not exclude you from the Application Process. You will, however, be required to meet with CURE representatives for an Admissions interview.

References must use the standard form provided with the application. Personally written letters of reference will be accepted in addition to, but not as a substitute for the standard forms. The forms must be mailed along with the application to the Program Director in envelopes sealed by the reference. Please list all individuals who will be used as references for your admission into the program.

Name	**Relationship to applicant**	**Length of relationship**
Name	**Relationship to applicant**	**Length of relationship**
Name	**Relationship to applicant**	**Length of relationship**

ADDITIONAL INFORMATION

Do you have a medical condition requiring special attention or medication? □ **Yes** □ **No**
If yes, please explain.

Have you ever been arrested or convicted of a felony? □ **Yes** □ **No**
If yes, please provide detailed in the space provided.

Are you a US citizen? □ **Yes** □ **No**

SIGNATURE

□ *I acknowledge that all transcripts or transcript translations and references have been submitted securely in sealed envelopes provided by the appropriate institution or individual.*

□ *I understand that all documents will be retained permanently by the school regardless of my admission status.*

□ *I understand that any falsified or inaccurate representation of my background will result in disqualification of my eligibility for admission.*

□ *I certify that the above information is complete and accurate. I am aware that this information will be verified.*

□ *To the best of my knowledge, I will meet all minimum requirements, including physical requirements, prior to the start of class.*

Student Signature _____ **Date** _____

In compliance with federal law, including the provisions of Title IX of the Education Amendment of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, CURE, Center for Ultrasound Research & Education does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, and sexual orientation consistent with CURE nondiscriminatory policy.

CHECKLIST

My application submission includes the following documentation:

_____ Application forms

_____ Verification of medical experience or equivalent

_____ Official transcripts for all post-secondary coursework in sealed envelope(s)

_____ Immunization medical records/forms and statement of good health signed by a medical doctor.

MAIL APPLICATION TO

Center for Ultrasound Research & Education
Attention: Admissions
Westchester Avenue, Suite 101W
White Plains, NY 10604

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MANDATORY IMMUNIZATION FORM

Last Name: First Name: Middle:
City/State/Zip:
Date of Birth: Social Security #:
Phone: Gender: (Circle One) Male Female

MMR COMBO (Measles, Mumps, Rubella) Two Doses OR One Dose and Positive Titer, OR Statement from Physician of History of Having Disease, OR Proof of Honorable Discharge from Military.

Note: Proof of Attendance in US School since 1980 is Valid For 1 Dose.

1) ____ /____ /____ (date) Given at _____
Enter location name, city and state

2) ____ /____ /____ (date) Given at _____
Enter location name, city and state

HEPATITIS B VACCINE: Three doses.

1) ____ /____ /____ (date) Given at _____
Enter location name, city and state

2) ____ /____ /____ (date) Given at _____
Enter location name, city and state

3) ____ /____ /____ (date) Given at _____
Enter location name, city and state

TUBERCULIN SKIN TEST
This test is to certify that the above-named individual is free of active tuberculosis.
This is based on A **TUBERCULIN SKIN TEST** GIVEN ON _____indicating ____**mm.**

Signature M.D. or Nurse **Printed Name** **Date**

In the event of allergic reaction to TB skin test or a positive skin test result, a chest x-ray or medical doctor's evaluation is required to rule out active tuberculosis.

Date of Chest X-Ray/Physician Assessment:
Findings:

Signature M.D. or Nurse **Printed Name** **Date**

STATEMENT OF GOOD HEALTH

I hereby certify that _____is in good health based on my assessment today.

Signature M.D. or Nurse **Printed Name** **Date**

Address Phone Number

City State Zip

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MENINGOCOCCAL MENINGITIS RESPONSE FORM

Failure to complete the following will result in being unable to attend **CURE.**
THIS LAW APPLIES TO ALL STUDENTS.

New York State Public Health Law 2167 requires that all college, university, and proprietary school students, complete the following form and be provided with information regarding Meningococcal Meningitis:

- Means of transmission
- Benefits, Risks and Effectiveness of Immunization
- Availability and Cost of Immunization\

I, _____ acknowledge receipt of the above information.
(print name)
I understand the material that has been provided to me by **CURE**, and will make an informed decision about being vaccinated for **Meningococcal Meningitis.**

Check one box and sign below.
I have (for students under the age of 18: My child has):

☐ had meningococcal meningitis immunization within the past 10 years. Date: _____

[Note: If you (your child) received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider or another authorized medical provider.

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____
(Parent / Guardian if student is a minor)

Print Student's name _____ Date of Birth _____

Student Mailing Address _____

Student E-mail address _____ Student SS # _____

Student Phone Number _____