Dear Student:
Thank you for your interest in Texas Southmost College and the Diagnostic Medical Sonography Program. The enclosed information will explain in more detail what the Sonography curriculum contains.

Minimum criteria to be considered for admission in the Diagnostic Medical Sonography Program are:

- Admission to TSC -- Contact the enrollment office for admission requirements (956) 295-3600
- Submission of completed Application for Admission to the DMS Program
- Submission of testing results that meet TSC testing requirements for admission
- Documentation of any certifications currently held
- Submission of two recommendation forms from physicians, employers, and/or instructors familiar with applicant's work
- A DMS Lab observation is required (schedule with Program Director)
- Unofficial TSC transcript showing all accepted transferred courses

Pre-program Courses (all grades must be posted on TSC transcript by application deadline):

BIOL	2301	Anatomy and Physiology I
BIOL	2101	Anatomy and Physiology Laboratory I
BIOL	2302	Anatomy and Physiology II
BIOL	2102	Anatomy and Physiology Laboratory II
MATH	1314	College Algebra (*with a grade of C or better*)
DMSO	1302	Basic Ultrasound Physics *(with a grade of C or better)*
ENGL	1301	Composition I

The applicant's grades in the following: BIOL 2301, 2101, 2302, 2102, MATH 1314, DMSO 1302, ENGL 1301, and entrance exam test results are reviewed and recorded. Certain applicants may be selected for an interview by the Admissions Committee. The previously mentioned considerations, including an interview rating, are weighed and a total point score is obtained. Applicants with the highest score ratings will be accepted in the Diagnostic Medical Sonography Program.

For more information please contact the Allied Health office at (956) 295-3731 or (956) 295-3764

Sincerely,

Ariel Villanueva

Dr. Ariel I. Villanueva
Director – Diagnostic Medical Sonography
ariel.villanueva@tsc.edu

Application and ALL other criteria are due by 12:00 Noon, on the last working day of May.
A criminal background check, physical exam, up-to-date immunizations, and CPR certification are required of all students prior to clinical assignments.

APPLICATION FOR PROGRAM ADMISSIONS

Select Program of Interest:

☐ Diagnostic Medical Sonography ☐ *Radiologic Technology ☐ Emergency Medical Science
☐ *Respiratory Care Science ☐ Medical Laboratory Technology

This application is for admission into the program beginning: ☐ FALL _____ / ☐ SPRING _____

** NOTE: Applicants must complete remedial requirements & program prerequisites by the application deadline of the term for which admission is sought.*

Date of Application: _____ Student ID #: _____

Full Legal Name: _____
Last *First* *Middle*

Current mailing address: _____
Street

_____
City *State* *Zip*

Current telephone: ( ) _____ *(where you can be reached between 8 a.m. and 5 p.m. on weekdays)*

Email Address: _____

If you have previously attended any school under a name other than that given above, please specify below:

_____

List other Allied Health Schools/Programs you have or will apply to:

Allied Health School	Date of Application
_____	_____
_____	_____

PERSONAL INFORMATION

☐ Male ☐ Female Place of Birth: _____

Ethnic Origin: (*OPTIONAL-for affirmative action purposes only*)

☐ White ☐ Hispanic ☐ Native American ☐ Prefer Not To Answer
☐ Black ☐ Asian ☐ International

Emergency Contact:

_____ _____
Name *Relationship*

_____
Street Address

_____ ( ) _____
City, State, Zip *Telephone*

Have you ever been convicted of a misdemeanor or felony (including deferred adjudication for either) with the exception of minor traffic violations (e.g. speeding or parking violations)? *Note: DUI's, DWI's, PI's are not minor traffic violations. ☐ Yes ☐ No
If "Yes," provide a written explanation.

Were you ever required to leave high school, college, graduate or professional school or ever denied readmission because of deficiencies either in conduct or scholarship? ☐Yes ☐ No If "Yes," provide a written explanation.

In order to provide better services for people with disabilities, the following voluntary information is needed. This is for affirmative action purposes. The information you provide will not affect your admission to the School of Health Sciences and will kept confidential.
Please check all that applies to you: ☐ physical disability ☐ learning disability ☐ other disability
Will you need accommodations in order to succeed in the program for which you are applying? ☐ yes ☐ no

EDUCATIONAL BACKGROUND

List the high school you attended and REQUEST THAT AN OFFICIAL TRANSCRIPT be sent the address shown below. *

Last High School Attended: _____ _____

School City/State Graduation Date

Please list each college or university that you have attended or will attend prior to enrolling at TSC. (*REQUEST THAT AN OFFICIAL TRANSCRIPT FROM EACH INSTITUTION SHOWING ALL WORK ATTEMPTED BE SENT DIRECTLY TO THE ADDRESS SHOWN BELOW).* *

NAME OF SCHOOL	CITY	STATE	DATES ATTENDED	DIPLOMA/DEGREE

NOTE: If you have attended more than three colleges, please list on a separate sheet.

Entrance exam (TASP, THEA, etc.) must be successfully completed prior to consideration of this application. *(Contact Testing Center, Student Services Building 956-295-3660 to arrange testing.)*

Date taken: _____ Or Scheduled: _____

List all college or university COURSES which **you are currently enrolled** or **will have completed before the program begins**, that DO NOT PRESENTLY APPEAR on your transcript.

COLLEGE OR UNIVERSITY	COURSE NO.	COURSE TITLE	CREDIT HRS	TERM/YR

I understand that the Admission Committee will not regard this application as "complete" until all supporting papers have been received; therefore, it is to my interest to see that these are submitted as promptly as possible. It is also my understanding that official transcripts sent directly from each school I have attended must be received as soon as possible and at the end of each successive semester, quarter, etc., for as long as my application is being considered. (Transcripts showing additional work after acceptance must also be submitted.)

If selected for admission to this program I will at all times conduct myself in accordance with the rules and regulations of the College, Program and its clinical affiliates. I certify that the information in this application is complete and correct and understand that the submission of false information is grounds for rejection of my application, withdrawal of any offer of acceptance, cancellation of enrollment, or appropriate disciplinary action.

_____ _____

Signature of Applicant *Date*

If there are circumstances which may have an influence on your admission which you would like for those reviewing your application to know about, please describe on a separate sheet and attach.

DEADLINES FOR RECEIPT OF APPLICATION AND ALL REQUIRED DOCUMENTS:

PROGRAM	PROGRAM BEGINS	APPLICATION DEADLINE
Emergency Medical Science	Fall Semester	June 15
Medical Laboratory Technology	Fall Semester	Last working day of June
Radiologic Technology	Spring Semester	Last working day of August
Respiratory Care Science	Fall Semester	Last working day of May
Diagnostic Medical Sonography	Fall Semester	Last working day of May (Noon)

* *Application, transcripts, and supporting documents should be hand delivered to:***(Indicate the Name of the Program)**

Texas Southmost College
ITEC Center
301 Mexico Blvd Ste H3A
Brownsville, Texas 78520-4993

The Texas Southmost College does not discriminate based on sex, race, color, national origin, handicap or age

Students please check one in this section. *(Required Essential Functions can be found in Program Brochure)*

☐ **RADIOLOGIC TECHNOLOGY** ☐ **DIAGNOSTIC MEDICAL SONOGRAPHY** ☐ **MEDICAL LABORATORY TECHNOLOGY**

☐ I have reviewed and understand the required program essential functions and I believe that I meet all these standards.

☐ I am not sure if I meet one or more of these functions and I need further evaluation. Check one or more the of the following:

☐ Vision ☐ Speech and Hearing ☐ Fine Motor Function ☐ Psychological Stability

RECOMMENDATION FORM

Name of Applicant:_____
Student ID#:_____
Applying to:_____

RELEASE OF ACCESS TO THIS LETTER OF RECOMMENDATION

The applicant must complete and sign the following statement before submitting this form to the recommender. This request is in compliance with Federal Law P. L. 93-380 (Family Educational Rights and Privacy act of 1974).

☐ I waive my right of access to this letter of recommendation.

☐ I do not waive my right of access to this letter of recommendation.

_____ _____
Signature of Applicant Date

RECOMMENDATION FOR THE DIAGNOSTIC MEDICAL SONOGRAPHY PROGRAM

1. **HOW WELL DO YOU KNOW THE APPLICANT?** ☐ Very Well ☐ Fairly Well ☐ Minimally ☐ Unknown

How long have you known the applicant? _____ Identify the capacities in which you have been associated with the applicant. ☐ Instruction ☐ Lecture ☐ Employer ☐ Counselor ☐ Undergraduate academic advising ☐ Graduate academic advising ☐ Co-worker
Other_____

2. **MOTIVATION FOR THE DIAGNOSTIC MEDICAL SONOGRAPHY PROGRAM:**

☐ Exceptionally good ☐ Good; no major weaknesses ☐ Poor ☐ Inadequate opportunity to observe
☐ Weak in some respects, such as_____

Additional Comments:
_____

3. **POTENTIAL FOR WORKING WITH PATIENTS:**

☐ Exceptionally good ☐ Good; no major weaknesses ☐ Poor ☐ Inadequate opportunity to observe
☐ Weak in some respects, such as_____

Additional Comments:
_____

4. **COMMUNICATION SKILLS:**

	Poor Expression	**Inappropriate Verbs, etc.**	**Accurate and Appropriate**	**Above Average**	**Excellent Observation**
Oral……	☐	☐	☐	☐	☐
Written…….	☐	☐	☐	☐	☐

Comments_____
_____

5. **WORK HABITS:** ☐ Works at full capacity ☐ Works well; has reserve capacity ☐ Satisfactory, but not best
☐ Inclined to "get by" ☐ Inadequate opportunity to observe

(Please complete reverse side)

6. **INTERPERSONAL RELATIONS WITH OTHERS:**
☐ Appropriate ☐ Poor ☐ Inadequate opportunity to observe ☐ Difficulties, such as_____

7. **PERSONALITY:** ☐ Satisfactory ☐ Objectionable ☐ Inadequate opportunity to observe

8. **MATURITY:** ☐ Mature ☐ Immature ☐ Inadequate opportunity to observe

9. In addition to your preceding responses, please give your personal evaluation of and your reaction to the applicant. (You may wish to amplify some of your previous comments.)

10. My recommendation is: ☐ Very Enthusiastic ☐ Strong ☐ Neutral ☐ Negative

Please print your name_____

Signed_____ Date_____

Position_____ Institution_____

Please Mail this letter to:

Texas Southmost College
Diagnostic Medical Sonography Program
ITECC H3A-200
301 Mexico Blvd.
Brownsville, Texas 78520

Required Lab Observation

*** Requirement: An application must be completed in your file

*** Observation form must be turned in before the application deadline

Please print this form once an observation appointment has been scheduled

Student Name: _____

Date: _____

Lab Course Observed: _____

Lab Course Instructor: _____

Total Hours Observed: _____

Comments: _____

_____

_____

_____

_____

Student Signature _____

Instructor Signature _____