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)? ☐ 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 be 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 to the address shown below.*

Last High School Attended: 

<table>
<thead>
<tr>
<th>School</th>
<th>City/State</th>
<th>Graduation Date</th>
</tr>
</thead>
</table>

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).*

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>CITY</th>
<th>STATE</th>
<th>DATES ATTENDED</th>
<th>DIPLOMA/DEGREE</th>
</tr>
</thead>
</table>

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 956-296-3660 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.

<table>
<thead>
<tr>
<th>COLLEGE OR UNIVERSITY</th>
<th>COURSE NO.</th>
<th>COURSE TITLE</th>
<th>CREDIT HRS</th>
<th>TERM/YR</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>PROGRAM BEGINS</th>
<th>APPLICATION DEADLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medical Science</td>
<td>Fall Semester</td>
<td>June 15</td>
</tr>
<tr>
<td>Medical Laboratory Technology</td>
<td>Fall Semester</td>
<td>Last working day of June</td>
</tr>
<tr>
<td>Radiologic Technology</td>
<td>Spring Semester</td>
<td>Last working day of August</td>
</tr>
<tr>
<td>Respiratory Care Science</td>
<td>Fall Semester</td>
<td>May 1</td>
</tr>
<tr>
<td>Diagnostic Medical Sonography</td>
<td>Fall Semester</td>
<td>Last working day of May (Noon)</td>
</tr>
</tbody>
</table>

* Application, transcripts, and supporting documents should be mailed to:  

(Indicate the Name of the Program) 

Texas Southmost College  
80 Fort Brown  
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)*

- [ ] RADILOGIC TECHNOLOGY  
- [ ] DIAGNOSTIC MEDICAL SONOGRAPHY  
- [ ] MEDICAL LABORATORY TECHNOLOGY  

I have reviewed 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 of the following:

- [ ] Vision  
- [ ] Speech and Hearing  
- [ ] Fine Motor Function  
- [ ] Psychological Stability
RECOMMENDATION FORM

Name of Applicant: __________________________ ID#: __________________________

Address: __________________________ Phone#: __________________________

Applying to: DIAGNOSTIC MEDICAL SONOGRAPHY

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 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:

<table>
<thead>
<tr>
<th>Poor</th>
<th>Inappropriate</th>
<th>Accurate and</th>
<th>Above</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expression</td>
<td>Appropriate</td>
<td>Average</td>
<td>Observation</td>
</tr>
</tbody>
</table>

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

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: Diagnostic Medical Sonography Program
Texas Southmost College
80 Fort Brown
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 __________________________