ST. MARY'S CENTER FOR EDUCATION

SCHOOL OF MEDICAL IMAGING

SONOGRAPHY PROGRAM APPLICATION

Applicants name: _____

(last name, first name)

Academic year and semester you are applying for: _____

Desired Sonography Specialty: _____

Contact Information:

Email address: _____

Phone number _____ _____

Home Address: _____ _____

City: _____ State_____ Zip Code: _____

Please give permission to your University or College to forward transcripts to the Sonography Director upon request.

If you have any questions, please contact:

Patricia Jane Mannon, MS, RDMS, RVT, VT, RT(ARRT)

Program Director

Diagnostic Medical Sonography Program

304-399-7120

Mannon.patricia@st-marys.org