

# IUD Transcript Review Form Instructions

Please READ these instructions carefully and complete all applicable items when submitting your form. Failure to follow instructions may cause your application to be discarded.

- 1) Complete ALL pages of this form and attach unofficial transcripts.
- 2) If you want to be considered as a distance student you must also complete the Clinical Site Preference section.
- 3) Send completed form and copies of your unofficial transcripts via email **in PDF FORMAT ONLY** to [mgill@iudmed.com](mailto:mgill@iudmed.com).

Applicants are highly encouraged to return this form by email, however you may send your information via fax to 251-621-6669, or via US mail to Micah Gill 1 Timber Way Ste 203 Daphne, AL 36527. If you choose to send by fax or regular mail you are encouraged to contact Micah Gill to ensure your information was received.

- 4) Once we have received your form and transcripts you will be notified via email of any pre-requisite class you still need as well as the other items needed to complete your file.

## Other important information

For each school, the terms local and distance student mean different things. For the purposes of IUD we define each as follows:

**LOCAL Students** – A Local student for the purposes of the 1 Year General Sonography Program is any student who lives in or around the following geographic perimeter: Foley, AL up to Atmore, AL over to Lucedale, MS and down to Gulfport, MS. If you live inside or just outside that perimeter you will be considered a local student and be required (if accepted) to rotate between our local clinical sites within that perimeter which includes driving up to 90 miles.

**Distance Students** – A distance student for the purposes of the 1 Year General Sonography Program is any student who lives outside of the above mentioned geographic perimeter. Distance students will not be accepted into the 1 Year program until they have secured a clinical site. To find out if we have clinical site near you, please make sure to complete the clinical site preference form.

If you have any questions regarding any of this information you can contact Micah Gill at [mgill@iudmed.com](mailto:mgill@iudmed.com) or by phone at 251-621-8668 ext 3.

### Transcript Review Form

Complete ALL pages of this application and return to the Admissions Office  
 by email: [mgill@iudmed.com](mailto:mgill@iudmed.com)

**Personal Information**

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Full Name: \_\_\_\_\_ Maiden: \_\_\_\_\_

Physical Address : \_\_\_\_\_  
 (No PO Box): \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Main Phone Number: \_\_\_\_\_ Other contact: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Desired 1 Year Program Start Date (Mark Year, Quarter, and Location)**

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Year: \_\_\_\_\_ Clinical Location:  LOCAL (Within 90 Miles of IUD)  
 DISTANCE (approved clinical site required)

Quarter:  JANUARY  APRIL  
 JULY  OCTOBER

**Previous Medical or Allied Health Training (NOT REQUIRED FOR ENTRY INTO PROGRAM)**

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Do you have any Medical or Allied Health Training?  YES  NO

If Yes, Check all that apply and list registry/license # next to the specialty if applicable.

	<u>registry/license #</u>		<u>registry/license #</u>
X-ray	<input type="checkbox"/> _____	Nursing (RN/LPN)	<input type="checkbox"/> _____
CT	<input type="checkbox"/> _____	Cert Nursing Asst.	<input type="checkbox"/> _____
Mamography	<input type="checkbox"/> _____	Other (list)	<input type="checkbox"/> _____

Name of Institution and Dates attended: \_\_\_\_\_.

Do you have previous Ultrasound experience?  YES  NO

If yes, how much? \_\_\_\_\_  Hands on  Observation only

