



**MT. SAN JACINTO COLLEGE  
DIAGNOSTIC MEDICAL SONOGRAPHY  
PROGRAM APPLICATION PACKET**

**APPLICATION FILING PERIOD: March 1st – 15th for Fall admission.**  
INCOMPLETE or INACCURATE application packets will automatically disqualify the applicant.

**NEW!** Applications will be accepted via:

- a. Scanned and emailed to the [NursingandAh@msjc.edu](mailto:NursingandAh@msjc.edu) email address. **Please Note:** Documents must be in PDF or JPEG format, **Must** include subject line: **FA2025 DMS Application**  
**OR**
- b. Downloaded, printed, and **delivered in a sealed envelope** to the Nursing and Allied Health Department during regular business hours.  
**Monday-Thursday 8:00A – 5:00P.**  
An email will be sent confirming the receipt

We will only accept one submission per student, per application period. Any subsequent submissions will not be considered part of your application.  
**Please Note:** Correspondence with students regarding application, surveys, and other communications from the MSJC Allied Health program will be via [MSJC student email and personal email only.](#)

**\*OVERALL PROGRAM REQUIREMENTS**

- a. Active admissions application on file with Mt. San Jacinto College
- b. Minimum age of 18
- c. Social security number
- d. High school diploma, GED, or California proficiency
- e. Completion of orientation workshop with attestation of in-person or online viewing of DMS Program power point presentation
- f. Required transcript assessment and counseling advisement: "Program Notes" with GPA listed
- g. Reliable transportation to all affiliated hospitals
- h. Cumulative GPA of at least 2.5 and a "C" or better on all prerequisite courses
- i. Upon Admission student must be able to pass drug screening, background check, and immunizations and/or vaccinations as required by DMS hospital affiliates.

**DOCUMENTS TO SUBMIT WHEN APPLYING**

- 1. Completed and signed Applicant Information Sheet
- 2. Eligibility Evaluation/Program Notes with listed GPA
- 3. TEAS Report: Official TEAS Report must be ordered from ATI and sent to MSJC ("CC" the AH Program); a copy of the Unofficial TEAS Report must be submitted with application packet
- 4. High School Diploma/GED/California Proficiency
- 5. College Diploma/Licenses/Certifications and/or Employment Verification
- 6. DMS Orientation Workshop Attendance Certificate
- 7. Completed Demographics Survey

**DOCUMENTS TO SUBMIT UPON ADMISSION**

- a. Students will receive acceptance letters via email (denial letters will also be sent out)
- b. Student must acknowledge acceptance letter and return to Allied Health Office via email
- c. Students will attend a mandatory orientation workshop in Summer
- d. Students will be required to complete and submit the following:
  - 1. CPR Card
  - 2. Liability Insurance (HPSO)
  - 3. Physical Exam
  - 4. Photo Release Form
  - 5. Immunizations- MMR, TDAP, Varicella, HEP B series or positive Titers for each

**DOCUMENTS TO SUBMIT BEFORE STARTING CLINICAL TRAINING**

- 6. Background Check
- 7. Drug Screening
- 8. Proof of personal health insurance

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9. Immunizations- MMR, TDAP, Varicella, HEP B series or positive Titers for each
10. Vaccinations- Annual Influenza or declination with face mask during flu season; Covid 2 series: Moderna or Pfizer OR 1 series J&J or Novavax
11. TB blood screening - QuantiFeron Gold or chest Xray if prior +

Specific instructions on how to complete post-acceptance documentation will be included in the program acceptance letter.

\*Please review both application and admission documentation requirements along with overall program requirements.

- During 1st Semester, Proof of these items must be uploaded onto Castlebranch, CB Bridges, and/or Complio. Any student who does not submit the required information will not be able to attend clinicals.

**PROGRAM ESTIMATED COSTS**

1. Students pay for tuition, ASB card and a parking permit as stated in the current college catalog
  2. Tuition - \$46.00 unit (57 units)
  3. Program uniforms designated by the Nursing-Allied Health Department \$70.00 for top/pants set
  4. DMS textbooks and supplies - \$600-\$800
  5. SDMS membership - \$40 OR AIUM student membership - \$25
  6. CPR course - \$65-\$95 (Must be American Heart Association/Healthcare Provider -BLS)
  7. Physical Examination/laboratory tests - \$300-\$500
  8. Background Clearance + Drug Screening + Medical Document Manager (Complio or CB Bridges)- \$50-\$200
  9. Transportation cost to and from training site- Variable
  10. Liability Insurance covering students is provided by the college at no cost to the student.
  11. Students will have to provide a Drug screening within 30 days of clinical placement.
  12. Trajecs account for clinical hours and exam tracking = \$150.00 (one-time cost for all semesters).
  13. Conferences: Edelman Physics conference (\$300), UCLA Fetal Echo Conference (\$125) and San Diego Perinatal Conference (\$25).
  14. After course completion: ARDMS SPI (Sonography Physics and Instrumentation) \$250 and Abdomen and OB-Gyn specialty exams - \$275 each = \$800.00 total.
- Students are required to carry their own Professional Liability Insurance (HPSO), \$1-3 million. Approx. \$50.
  - Students are required to show proof of Personal Health Insurance, which is required by Clinical Sites.

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**DMS PROGRAM SELECTION CRITERIA**

Please Note: : Once the application window closes, all completed packets will be reviewed and scored using the multi-criteria point system. Admission will be offered to the highest-ranking applicants whose documentation supports the information provided in the application.

Criteria	Maximum Points for Each Category	Point Distribution and Explanation
1. Previous Academic Degrees, Diploma = AA/AS or BA/BS or higher	10	Points are given for any prior degrees or multiple degrees. Score will either be 10 points or 0 points-multiple # of degrees do not add points
2. Licensed Healthcare work, Certified Healthcare work, or Employment Documentation. <u>MUST BE DIRECT PATIENT CARE</u> Volunteer hours do not count.  *See adjacent column: License, Certificate, or Employment history must be direct patient care. Volunteer hours do not count.	10	Points for this criterion are given for health care licensing, certificate, or employment documentation.  <b>Licenses/Certifications/Employment must have documentation</b> Score will be either 10 points or 0 points-multiple # licenses/certifications do not add points.  *Examples of Approved Direct Patient Care, including but not limited to: <b>Licenses/Certifications/Employment:</b> Imaging Technologist (RT): X-ray, MRI, CT, Nuclear Medicine, Mammography, CNA, LVN, RN, MA, HHA, Paramedic, EMT, Respiratory Therapist, Physical Therapist, Dental Hygienist, Phlebotomist, Doula, EKG, IHSS, Esthetician, Optician, Chiropractic assistant, Massage therapist etc.
3. GPA from Prerequisite Courses <u>Minimum GPA to apply is 2.5</u>	40	3.9 – 4.00 = 40 points 3.7 – 3.89 = 35 points 3.5 – 3.69 = 30 points 3.3 – 3.49 = 25 points 2.5 – 3.29 = 20 points
4. Completion of all General Education Units	5	Points for these criteria are given for completion of all General Education requirements. (Option A)
5. Approved Diagnostic Assessment Tool = Test of Essential Academic Skills (TEAS VI) or most current version. <u>Minimum score to apply is 70%</u> For Study Material & Test Registration visit: ATI website: <a href="http://www.atitesting.com">www.atitesting.com</a>	35	Points for TEAS is a maximum of 35 points. Score 90 to 100% = 35 points Score 82 to 89% = 30 points Score 74 to 81% = 25 points Score 70 to 73% = 20 points (The highest score on the TEAS will be accepted, limit of 2 attempts per application period)
<b>As of March 2022:</b> An additional 2 points for each year student submitted a complete application packet.		Two points will be added for each year student submitted a complete application packet.
<b>TOTAL MAXIMUM POINTS</b>	<b>100</b>	Two points will be added each year for an application that contains *all application requirements (current year does not add point)



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APPLICANT INFORMATION SHEET

Last Name First Name MI

Previous Name (If Applicable) MSJC Student ID #

MSJC Email Address Personal Email Address

Mailing Address City State CA Zip

Primary Phone # Alternate Phone # (Optional)

- How did you learn/hear about the MSJC DMS Program? Please check all that apply.
DMS Workshop High School Career Fair MSJC Catalog Middle School Career Day
MSJC Counselor Parent /Friend MSJC Event MSJC Winter Discovery Camp
MSJC Website Elementary Career Day Healthcare Professional Other

Have you ever been convicted of a felony/misdemeanor? NO YES
Have you ever violated the Student Code of Conduct at any College and/or University? NO YES

\*If yes, you must attach a one-page statement explaining the incident and any supporting documentation. Marking yes, does not disqualify you from the program, but assists the program faculty to develop a strategic plan to help you be successful in the program.

TEAS Results: (Please Fill In)
Adjusted Individual Score:
Institution where TEAS was completed:
Date TEAS was taken:
Please Contact MSJC Nursing & Allied Health Department to verify that your official TEAS scores were received from ATI.

- Please read and sign below to acknowledge of the following statements:
-I understand the approximate expenses for participation in the Associate Degree Diagnostic Medical Sonography Program and I am aware that expenses are subject to change.
-I agree to the cost of tuition, ASB and a parking permit as stated in current MSJC catalog.
-I have read the enclosed program requirements.
-I understand clinical training sites are as far away as Palm Springs and that I need reliable transportation to my site.
-I will notify the Nursing & Allied Health Department of any change in name/address/phone number immediately.
-I hereby give permission for Enrollment Services to share information (including transcripts, grades, and evaluation results) with MSJC Nursing & Allied Health Department.
-I understand admission to the program will be compromised if I am unable to be reached.
-I understand that my admission to the program is contingent upon submission of all post-acceptance documentation.
-I have included all necessary proof and required documents within my packet.
-I hereby acknowledge all information provided is true and accurate, to the best of my knowledge. I understand that failure to disclose accurate information will result in my application being removed from consideration and/or dismissal from program upon acceptance.

Student Signature: Date:



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EMPLOYMENT VERIFICATION: CRITERIA 2

This document must be submitted to verify work experience for the DMS Program application packet. Licensed Healthcare work, Certified Healthcare work, or employment must be DIRECT PATIENT CARE. Volunteer hours do not count.

Examples of approved Direct Patient Care or direct patient care internship experience include, but are not limited to: Imaging Technologist (RT): X-ray, MRI, CT, Nuclear Medicine, Mammography, CNA, LVN, RN, MA, HHA, Paramedic, EMT, Respiratory Therapist, Physical Therapist, Dental Hygienist, Phlebotomist, Doula, EKG, IHSS, Esthetician, Optician, Chiropractic Assistant, Massage Therapist  
Etc.

EMPLOYEE NAME: \_\_\_\_\_

START DATE/ END DATE: \_\_\_\_\_

TOTAL NUMBER OF HOURS COMPLETED: \_\_\_\_\_

EMPLOYEE TITLE: \_\_\_\_\_

LIST OF DUTIES/RESPONSIBILITIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYER/SUPERVISOR SIGNATURE: \_\_\_\_\_

EMPLOYER/SUPERVISOR PRINTED NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

ORGANIZATION/ Email: \_\_\_\_\_

PLEASE CAPTURE BUSINESS CARD/COMPANY CONTACT INFORMATION BELOW:



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11. Average weekly hours of employment:
- |  |  |
|--|--|
| <input type="radio"/> Currently not working      | <input type="radio"/> 24 hours, but less than 32 |
| <input type="radio"/> Less than 8 hours          | <input type="radio"/> 32 hours, but less than 40 |
| <input type="radio"/> 8 hours, but less than 16  | <input type="radio"/> 40 hours or more           |
| <input type="radio"/> 16 hours, but less than 24 |  |
12. Have you had previous experience in health care?
- |                           |                          |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|
13. Years working health care:
- |   |  |
|---|--|
| <input type="radio"/> None                          | <input type="radio"/> 3 years, but less than 6 years |
| <input type="radio"/> Less than 1 year              | <input type="radio"/> 6 years, but less than 9 years |
| <input type="radio"/> 1 year, but less than 3 years | <input type="radio"/> 9 years or more                |
14. Health occupations experience:
- |   |   |
|---|---|
| <input type="radio"/> None                                  | <input type="radio"/> Certified Nurse Assistant                     |
| <input type="radio"/> College course: community involvement | <input type="radio"/> Volunteer work in a health care setting       |
| <input type="radio"/> College course: paid work experience  | <input type="radio"/> Paid work experience in a health care setting |
| <input type="radio"/> Licensed Vocational Nurse             | <input type="radio"/> Other _____                                   |
15. Highest educational level completed:
- |   |  |
|---|--|
| <input type="radio"/> High school/GED   | <input type="radio"/> Associate degree         |
| <input type="radio"/> Bachelor's degree | <input type="radio"/> Master's degree or above |
16. Did you move from out of state to attend this program?
- |                           |                          |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|
17. Program prerequisite courses taken at this college:
- Anatomy & Physiology (ANAT 101 & 102)
  - Interpersonal Communication (COMM 103)
  - Conceptual Physics (PHY 100)
  - Elementary Algebra (MATH 90)
  - N/A
18. Do you receive a scholarship or financial aid? Mark all that apply.
- |                                  |  |
|----------------------------------|--|
| <input type="radio"/> Pell Grant | <input type="radio"/> GAIN                           |
| <input type="radio"/> Employer   | <input type="radio"/> Local organization scholarship |
| <input type="radio"/> N/A        |  |
19. Are you eligible to receive a BOGG Grant through any of the following: Pell Grant, GAIN, JOBS, JTPA, SST, General Assistance, AFOC, any other form of economic public assistance, and/or annual income level below \$7,500 for single person, \$15,000 per couple with \$1,000 additional for dependent child?
- |                           |                          |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|