



**APPLICATION FOR RESIDENCY POSITION  
Master of Science in Diagnostic Imaging**

**SECTION 1: PERSONAL INFORMATION**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone 1: \_\_\_\_\_  Please contact me via this number

Telephone 2: \_\_\_\_\_  Please contact me via this number

E-mail: \_\_\_\_\_

**SECTION 2: COLLEGES/UNIVERSITIES ATTENDED**

Please include undergraduate, graduate, and chiropractic institution(s).

List in chronological order, starting with the most recent. Please attach a separate page if necessary.

1. College: \_\_\_\_\_

Location (City, State): \_\_\_\_\_

Dates of matriculation (month, year): From: \_\_\_\_\_ To: \_\_\_\_\_

Degree(s) earned, including year degree was granted: \_\_\_\_\_

2. College: \_\_\_\_\_

Location (City, State): \_\_\_\_\_

Dates of matriculation (month, year): From: \_\_\_\_\_ To: \_\_\_\_\_

Degree(s) earned, including year degree was granted: \_\_\_\_\_

3. College: \_\_\_\_\_

Location (City, State): \_\_\_\_\_

Dates of matriculation (month, year): From: \_\_\_\_\_ To: \_\_\_\_\_

Degree(s) earned, including year degree was granted: \_\_\_\_\_

4. College: \_\_\_\_\_

Location (City, State): \_\_\_\_\_

Dates of matriculation (month, year): From: \_\_\_\_\_ To: \_\_\_\_\_

Degree(s) earned, including year degree was granted: \_\_\_\_\_

**SECTION 3: PROFESSIONAL INFORMATION**

At the time of application, are you:

Yes  No Currently matriculated in chiropractic college? If yes, estimated graduation: \_\_\_\_\_

Yes  No Currently licensed to practice chiropractic?

Yes  No Eligible for chiropractic licensure in the state of New York?  
*If no, please explain on a separate page.*

Please list all current and former state/provincial chiropractic licenses, as well as any other professional licenses. Please attach a separate page if necessary.

1. Type of professional license, e.g. DC, MD, LAc: \_\_\_\_\_

Issuing state (if outside the US, please list province and country): \_\_\_\_\_

License number: \_\_\_\_\_

Dates of licensure: From: \_\_\_\_\_ To: \_\_\_\_\_

2. Type of professional license, e.g. DC, MD, LAc: \_\_\_\_\_

Issuing state (if outside the US, please list province and country): \_\_\_\_\_

License number: \_\_\_\_\_

Dates of licensure: From: \_\_\_\_\_ To: \_\_\_\_\_

3. Type of professional license, e.g. DC, MD, LAc: \_\_\_\_\_

Issuing state (if outside the US, please list province and country): \_\_\_\_\_

License number: \_\_\_\_\_

Dates of licensure: From: \_\_\_\_\_ To: \_\_\_\_\_

Please answer the following:

Yes  No Is/are your chiropractic license(s) in good standing?

Yes  No Have you ever been subject to disciplinary action by a professional licensing body?  
*If yes, please explain on a separate page.*

Yes  No Have you ever been subject to a malpractice suit?  
*If yes, please explain on a separate page.*

Yes  No Have you ever been convicted of a crime, including DWI but excluding minor traffic violations?  
*If yes, please state the date, offense, jurisdiction, and disposition of conviction on a separate page.*  
*Please note: criminal conviction is not an absolute bar to employment but will be considered only in relation to job requirements.*

## Application for Northeast College of Health Sciences MSDI Residency

I hereby certify that the information submitted on this application is true and complete to the best of my knowledge and belief. I understand that falsification of any of the information contained herein shall be grounds for disqualification from further consideration or for immediate dismissal from employment. I also understand that if I am appointed as a resident, my signature below authorizes Northeast College of Health Sciences to use my name and/or picture in catalogs and/or all College publications. This authorization will continue to be valid unless it is withdrawn by me in writing. Withdrawal shall not affect any publications that are in circulation and the institution shall not be required to delete my name until a new issue is reprinted. I further certify that upon accepting appointment to Northeast College, I agree not to function as a private entrepreneur in the offering of outside classes or educational materials to students, doctors of chiropractic, or chiropractic assistants unless the course or materials are offered under the auspices of Northeast College. It is also my understanding that under specific terms and conditions, special permission may be granted by the Administration for such course offerings.

---

Signature of Applicant

---

Date

The following materials are required to be complete your application portfolio:

- Completed Application for Residency Position
- Letter of intent, including your vision and goals as a future chiropractic radiologist
- Current Curriculum Vitae
- Copies of all professional licenses
- Copy of Bachelor's degree diploma
- Copy of Doctor of Chiropractic diploma
- 3 letters of recommendation
  - 1 from the Department Chair or Head of Radiology from the institution granting your DC
  - 2 letters from professionals, at least one from a chiropractor
- Official transcripts from:
  - All undergraduate institutions
  - Institution granting your Doctor of Chiropractic degree
  - Any other graduate level institutions
  - US National Board of Chiropractic Examiners

This application and all other documents are to be sent directly to:

Christine McDermott  
Office of Human Resources  
Northeast College of Health Sciences  
2360 State Route 89  
Seneca Falls, NY 13148  
315-568-3105  
[cmcdermott@northeastcollege.edu](mailto:cmcdermott@northeastcollege.edu)

Please direct any questions you may have to the Director of the MSDI program:

Chad D. Warshel, DC, DACBR  
315-568-3297  
[cwarshel@northeastcollege.edu](mailto:cwarshel@northeastcollege.edu)