APPLICATION FOR PARKVIEW MEDICAL LABORATORY SCIENCE PROGRAM

NAME OF APPLICANT - Last, First, Middle	LAST 4 DIGITS OF SSN XXX-XX- ___ ___ ___ ___

U.S. CITIZEN	IF NATURALIZED, PLACE and CERTIFICATION NUMBER

PRESENT ADDRESS - Street, City, State, ZIP Code	TELEPHONE NUMBER
PERMANENT ADDRESS - Street, City, State, ZIP Code	TELEPHONE NUMBER

NAME OF NEXT KIN	RELATIONSHIP	ADDRESS - Street, City, State, ZIP Code

HIGH SCHOOL - Name and Location	Yr. Completed
COLLEGE - Name and Location	Yr. Completed

SEMESTER HOURS COMPLETED	SEMESTER HOURS IN PROGRESS	APPROXIMATE GRADE POINT AVERAGE	MAJOR	MINOR (if applicable)

START PROGRAM - Please select the season and provide the year you would prefer to start this program:

☐ Summer – Year:_____ ☐ Winter – Year:_____

RECOMMENDATIONS

NAME	SUBJECT TAUGHT / NAME OF BUSINESS
(CHEM) _____	_____
(BIO) _____	_____
(Other) _____	_____
(Other) _____	_____

YOUR E-MAIL ADDRESS

PERSON TO NOTIFY IN CASE OF EMERGENCY:

_____ (NAME)	_____ (ADDRESS - Street, City, State)
_____ (BUSINESS PHONE)	_____ (HOME PHONE)

The above answers are true and complete to the best of my knowledge. My personal, financial, and business affairs are so arranged that uninterrupted attendance may be expected if I am appointed

_____ (SIGNATURE OF APPLICANT) _____ (DATE)

RETURN THIS APPLICATION TO:

Allegra McMillen, MEd, MLS(ASCP)^{CM}
Medical Laboratory Science Program Director
Parkview Hospital Randallia • 2200 Randallia Drive • Fort Wayne, IN 46805
OR Allegra.McMillen@Parkview.com