# APPLICATION FOR PARKVIEW MEDICAL LABORATORY SCIENCE PROGRAM

| NAME OF APPLICANT - Last, First, Middle | LAST 4 DIGITS OF SSN<br>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 |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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