UCI MEDICAL CENTER MEDICAL TECHNOLOGY PROGRAM - APPLICATION FORM

Last Name, First Name, Middle			Application Date		
Current Address: Street, City, State, Zip			Message Phone		
Permanent Address (if different)			Alternate Phone		
Alternate Last Name	E-mail address		Social Security Number		
New Application ☐	Reapplication ☐		For training to begin on or after (date):		
Do you have, or have you applied for a California Clinical Laboratory Scientist Trainee License? Yes ☐ No ☐					
License #:	Expiration Date#:		If pending, give date started:		
Are you an U.S. citizen? Yes ☐ No ☐ Have you filed a letter of intent to become an U.S. Citizen? Yes ☐ No ☐			If you are NOT an U.S. citizen, do you have a legal permit to work in the U.S.? Yes ☐ No ☐ Visa Status and #:		
Emergency Contact Relationship:	Last name, First name			Phone	
	Address: Street, City			State, Zip	
Type of School Jr Col/Col/Univ	School Name and Address	Major Subject	Degree	Attended From (mo/yr)	To (mo/yr)
Overall GPA	Science GPA		Has your GPA improved during the last two years of college? Yes ☐ No ☐		
Please list the names, addresses, and telephone numbers of two science instructors and one former or current employer from whom letters of recommendation will be received.					

List all biological science, chemistry, physics & math courses chronologically (group by discipline and where taken)	Smst units	Qtr units	Year	Lect (x)	Lab (x)	Grade	In Progress (x)	To do (x)
Biochemistry								
Analytical Chemistry (Quant. Analysis)								
Medical Microbiology								
Hematology								
Immunology								

List all biological science, chemistry, physics & math courses chronologically (group by discipline and where taken)	Smst units	Qtr units	Year	Lect (x)	Lab (x)	Grade	In Progress (x)	To do (x)

List all academic honors, extracurricular activities and hobbies:

Dates Employed	List most recent employer and/or volunteer position first			
From (mo/yr)	Firm Name	Job title	Salary	**Reason for leaving**
	Street Address	Duties	Hrs/wk	
To (mo/yr)	City, State, Zip	Supervisor	Phone#	
From (mo/yr)	Firm Name	Job title	Salary	**Reason for leaving**
	Street Address	Duties	Hrs/wk	
To (mo/yr)	City, State, Zip	Supervisor	Phone#	
From (mo/yr)	Firm Name	Job title	Salary	**Reason for leaving**
	Street Address	Duties	Hrs/wk	
To (mo/yr)	City, State, Zip	Supervisor	Phone#	
From (mo/yr)	Firm Name	Job title	Salary	**Reason for leaving**
	Street Address	Duties	Hrs/wk	
To (mo/yr)	City, State, Zip	Supervisor	Phone#	
From (mo/yr)	Firm Name	Job title	Salary	**Reason for leaving**
	Street Address	Duties	Hrs/wk	
To (mo/yr)	City, State, Zip	Supervisor	Phone#	

How did you hear about this Training Program?

☐ CA Dept of Public Health website ☐ ASCP website ☐ UCI Extension ☐ College advisor ☐ Other ______________

I certify that the foregoing responses I have given to all questions asked are true and correct, and understand that any falsification or intentional omission will be cause for denial of acceptance into this clinical training program.

Signature:	Date:

Applications submitted in compliance with stated requirements will be considered valid for up to one year following the initial application period.