UC IRVINE PHLEBOTOMY TRAINING PROGRAM APPLICATION

(Please *type* or *print clearly* in black or blue ink*)*

Applying for session (Beginning Month): 1) ☐ Spring (March) 2) ☐ Fall (August)	Year:	Application Date:

Desired Training (check one response)

☐ 20 hours **Advanced Didactic only** (must have >1040 hours on-the-job phlebotomy experience in the last 5 years)*

☐ 40 hours **Basic and Advanced Didactic only** (have <1040 hours on-the-job phlebotomy experience in the last 5 years and have performed at least 50 venipunctures and 10 skin punctures)*

☐ 40 hours **Basic and Advanced Didactic + 100 hours Clinical Practice** (no previous phlebotomy experience)

* Must provide official document(s) for verification

PERSONAL INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle
Address: Street, City, State, Zip		
Phone	Alternate Phone	E-mail address (print)
Are you an U.S. citizen? Yes ☐ No ☐	If you are NOT an U.S. citizen, do you have permanent residency? Yes ☐ No ☐ Visa Status:	
Emergency Contact: Last Name, First Name	Phone	
Emergency Contact Address: Street, City, State, Zip		

Language Capability (indicate Poor, Passable, or Fluent)	English (spoken):	English (written):
	Others (spoken):	Others (written):

EDUCATIONAL BACKGROUND

High School Graduate?: Yes ☐ No ☐	GED Completion: Yes ☐ No ☐ If YES, give date:		
High School (from which you graduated)*****	City/Country	Dates Attended	Graduation Date
Overall High School GPA	List all academic honors, extracurricular activities and hobbies		

	School Name and Address *	Major	City/Country	Dates Attended		Degree(s)
College/ University				From (mo/yr)	To (mo/yr)	
College/ University				From (mo/yr)	To (mo/yr)	
College/ University				From (mo/yr)	To (mo/yr)	
College/ University				From (mo/yr)	To (mo/yr)	

*** Please provide official school transcript(s) for school(s) attended**

Overall College / University GPA	List all academic honors, volunteer services, extracurricular activities and hobbies

WORK EXPERIENCE

Institution Name and Address	Job Title	Duties	Hours /Week	Salary	Dates Employed	Reason for Leaving

REFERENCES (TWO/THREE)

Please list the name(s), address(es), and telephone number(s) of one (or more) teacher(s) and one former or current employer from whom letters of recommendation will be received.

1) Name of Teacher, address and phone number _____

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2) Name of Teacher, address and phone number _____

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3) Name of employer, address and phone number _____

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How did you hear about this Training Program?

☐CA Dept of Public Health website ☐School advisor ☐Friend ☐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.

Applicant's Signature:	Date: