APPLICATION DATA

Franciscan Health- Hammond (St. Margaret)
Medical Laboratory Science Program (Medical Technology)

Rosemary Duda
5454 HOHMAN AVE.
HAMMOND, IN 46320
(219) 407-6399

PERSONAL DATA

NAME ____ LAST 4 DIGITS OF SOC. SECURITY NO. ____________________
Last First Middle

PERMANENT/HOME ADDRESS ____
No./Street City/State Zip code

TELEPHONE ____________________________ E-MAIL ADDRESS __________________________
Area Code Number

CURRENT MAILING ADDRESS ____
No./Street City/State Zip code

CELL PHONE ___________________________ BIRTHDAY: MONTH & DAY ONLY ____________________
Area Code Number

ARE YOU A CITIZEN OF THE UNITED STATES? YES ______ NO_______
IF NOT,WHAT TYPE OF VISA DO YOU CURRENTLY POSSESS? ___________IF YOU ARE ON AN F1 VISA, YOU MUST ALSO SUBMIT A COPY OF YOUR VISA, YOUR I-20 AND SOCIAL SECURITY CARD.

FOR THE MOST RECENT JOBS HELD, LIST NAME & ADDRESS OF EMPLOYER, JOB TITLE, LENGTH OF EMPLOYMENT & REASON FOR LEAVING:

1. ____

2. ____

3. ____

ACADEMIC DATA

HIGH SCHOOL (S) ATTENDED CITY/STATE ATTENDED FROM-TO

____

____

DID YOU GRADUATE FROM HIGH SCHOOL? YES _______ NO_______

COLLEGES, UNIVERSITIES OR PROFESSIONAL SCHOOLS ATTENDED SINCE HIGH SCHOOL

NAME/ADDRESS OF SCHOOL CITY/STATE FROM-TO: DEGREE: MAJOR

____

____

Please list references below and I will send a form letter for them to fill out. (exception Purdue Laf. Students. References are given forms by students) They do not have to write a free standing letter! Make sure to include their full address or e-mail address.

REFERENCES (Please sign waiver option: see attached)

1. SCIENCE PROFESSOR ________________________________ CLASS TAUGHT _______________

   ACADEMIC INSTITUTION/DEPT. ________________________ FULL ADDRESS/E-mail ________________________________

2. SCIENCE PROFESSOR _________________________________CLASS TAUGHT _______________

   ACADEMIC INSTITUTION/DEPT. _______________________FULL_ADDRESS/ e-mail __________________________________

3. SCIENCE PROFESSOR _________________________________CLASS TAUGHT _______________

   ACADEMIC INSITUTION/DEPT.________________________ FULL ADDRESS/e-mail __________________________________

4. OTHER REFERENCE (EMPLOYER, OTHER) ____

   ADDRESS/e-mail ____

If information is requested about you and may be filed under a different name, please indicate the other name.

____

If accepted, would you be able to begin the Program on date specified? ____________

PLEASE BE REMINDED THAT IN ORDER FOR THIS APPLICATION TO BE PROCESSED, YOUR $20.00 APPLICATION FEE MUST BE INCLUDED, ALONG WITH A SHORT PARAGRAPH STATING YOUR REASONS FOR PURSUING A CAREER IN MEDICAL TECHNOLOGY. CHECKS SHOULD BE MADE OUT TO: FRANCISCAN HEALTH HAMMOND

ALSO, AT THIS TIME, PLEASE HAVE FORWARDED TO US ALL COLLEGE TRANSCRIPTS.

FRANCISCAN HEALTH- HAMMOND IS AN EQUAL OPPORTUNITY INSTITUTION THAT DOES NOT DISCRIMINATE ON THE BASIS OF AGE, SEX, MARITAL STATUS, RACE, RELIGION, NATIONAL ORIGIN OR ANY OTHER FACTORS AS PROHIBITED BY LAW.

I certify that the information contained in this application is true, correct & complete to the best of my knowledge. I also agree that any falsified information or significant omissions may disqualify me from placement and may be considered justification from dismissal from the Program. I understand that placement at Franciscan Health - Hammond School of Medical Laboratory Science (Medical Technology) is not guaranteed. I also understand I may terminate the arrangement at any time and for any reason with or without notice and that Franciscan Health- Hammond has the same rights if I do not meet the obligations established by the Program. I understand that if placed at Franciscan Health- Hammond, I will conform to the rules & regulations of the hospital and the clinical program. I also agree to meet all the requirements the facility has outlined for employment, even if I choose not to be employed. These policies are available upon request & are provided upon entrance into the Program. I acknowledge that these rules may be changed, interpreted, withdrawn or added to at any time at the discretion of the facility. I also understand that any information provided may only be shared with other members of the acceptance committee for this Program and no others without my written consent. My signature below indicates acceptance of these terms.

REMEMBER THAT ALL INTERVIEWS ARE GRANTED AT THE DISCRETION OF THE PROGRAM DIRECTOR AFRER REVIEW OF ALL APPLICATION MATERIALS.

SIGNATURE ____ DATE ____________

WAIVER OPTION

THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974 OPENS MANY STUDENT RECORDS FOR THE STUDENT'S INSPECTION. THE LAW ALSO PERMITS THE STUDENT TO SIGN A WAIVER RELINQUISHING HIS OR HER RIGHT TO INSPECT LETTERS OF REFERENCE OR RECOMMENDATIONS.

PLEASE BE AWARE THAT MANY PROFESSORS ARE RELUCTANT TO WRITE LETTERS OF REFERENCE UNLESS THEY KNOW THEY ARE WRITING THE LETTERS IN CONFIDENCE.

PLEASE SIGN BELOW AFTER INDICATING WHETHER YOU DO____OR DO NOT____ WAIVE THIS RIGHT, REGARDING THE REFERENCES YOU HAVE LISTED ON YOUR APPLICATION.

SIGNATURE ________________________________ DATE __________________