APPLICATION for the PARKVIEW MEDICAL LABORATORY SCIENCE PROGRAM

PERSONAL INFORMATION

NAME OF APPLICANT – Last (Maiden, if applicable), First, Middle			LAST 4 DIGITS OF SSN XXX – XX – __ __ __ __
EMAIL ADDRESS	U.S. CITIZEN?	IF NATURALIZED, PLACE and CERTIFICATION NUMBER	
PHONE NUMBER	PRESENT ADDRESS – Street, City, State, ZIP Code		
PERMANENT ADDRESS – Street, City, State, ZIP Code			
EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE	ADDRESS – Street, City, State, ZIP Code
NEXT OF KIN – If differs from above.	RELATIONSHIP	PHONE	ADDRESS – Street, City, State, ZIP Code

EDUCATION INFORMATION

HIGH SCHOOL – Name and Location			YEAR COMPLETED
COLLEGE OR UNIVERSITY 1 – Name and Location			YEAR COMPLETED (or expect to)
COLLEGE OR UNIVERSITY 2 – Name and Location			YEAR COMPLETED (or expect to)
COLLEGE MAJOR(S)	COLLEGE MINOR – If applicable	SELECT A SYSTEM:	☐ Semesters ☐ Quarters ☐ Other: _____
CREDIT HOURS COMPLETED	CREDIT HOURS IN PROGRESS	CUMULATIVE GRADE POINT AVERAGE COLLEGE 1	CUMULATIVE GRADE POINT AVERAGE COLLEGE 2

PROGRAM APPLICATION INFO

PROGRAM START – Please indicate the season and year you would prefer to start the MLS program.

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

REFERENCES

DEPT.	NAME OF REFERENCE	SUBJECT TAUGHT/NAME OF BUSINESS
CHEM		
BIO		
OTHER		
OTHER		

ATTESTATION & SIGNATURE – My signature attests that my answers are accurate and complete to the best of my knowledge. My personal, financial, & business affairs are so arranged that uninterrupted attendance in the program is realistically achievable if I am accepted.

APPLICANT SIGNATURE	DATE

RETURN THIS APPLICATION to the MLS Program Director Allegra McMillen MEd, MLS(ASCP)^{CM} **In 1 of these 2 ways:**	Via Email (Preferred for faster processing)	Allegra.McMillen@Parkview.com
	OR Via Regular Mail	Allegra McMillen MEd, MLS(ASCP)^{CM} Parkview Hospital Randallia, MLS Program 2200 Randallia Drive Fort Wayne, IN 46805