

APPLICATION

Rochester General Hospital Clinical Laboratory Technology Program

Attention: Nancy C. Mitchell, MS, MT(ASCP), DLM

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Name: First _____ MI _____ Last _____

School Address: Street: _____ **Phone:** _____

City: _____ State: _____ Zip: _____

Home Address: Street: _____ **Phone:** _____

City: _____ State: _____ Zip: _____

E-mail _____ **Cell phone:** _____

Education: High School: _____ Year Graduated: _____

College Name	Years Attended	Year Graduated	Degree

Work Experience:

References (include at least two Science Faculty members and one personal):

1. Name: _____
Street: _____ City: _____ State: _____ Zip: _____
2. Name: _____
Street: _____ City: _____ State: _____ Zip: _____
3. Name: _____
Street: _____ City: _____ State: _____ Zip: _____

Required: Include a brief statement explaining why you have chosen the profession of Medical Technology/Clinical Laboratory Science as your career.

I declare that all the above information is true to the best of my knowledge, and any misrepresentation will be cause for my rejection or dismissal. I hereby authorize Rochester General Hospital Clinical Laboratory Technology Program to obtain information from my educational background and references as deemed necessary to determine my suitability for the Clinical Laboratory Technology Program. I also authorize the release of information concerning my school performance and grades.

X _____

Signature of Applicant

_____ Date

Received: App ___ HS Tx ___ Coll Tx ___ Ref 1 2 3 Essential Fns: ___ Fall Grades ___