



University Laboratories
 Detroit Medical Center / Wayne State University
CYTOTECHNOLOGY PROGRAM
APPLICATION FORM

Please type or print legibly.

Year for which you are applying _____

NAME: _____ SOCIAL SECURITY NO: _____
Mr/Miss/Mrs/Ms Last First Middle

CURRENT ADDRESS: _____
Street Apt # City State Zip

PERMANENT ADDRESS: _____
(If different from above) Street Apt # City State Zip

CURRENT TELEPHONE: Daytime (Include area code or country/city code) _____
 Evening (Include area code or country/city code) _____

PERMANENT TELEPHONE: (Include area code or country/city code) _____
(If different from above)

EMAIL ADDRESS: _____

PERSON TO BE NOTIFIED INCASE OF ACCIDENT OR EMERGENCY

NAME: _____ TELEPHONE: _____

ADDRESS: _____

Have you previously applied to this Cytotechnology Program? Yes _____ No _____
 Are you a citizen of the United States? Yes _____ No _____
 If No, do you have a visa? Yes _____ No _____
 If yes, specify visa # _____ Date of expiration: _____

Please note that securing the appropriate visa for applicants outside the United States is the responsibility of the applicant. You must be able furnish evidence of legal residence (e.g., visa, greencard, citizenship certificate, passport, etc.)

Have you ever served in the armed forces? Yes _____ No _____
 If yes, Specify branch _____ From: _____ To: _____

Have you ever been convicted of a felony? Yes _____ No _____
 If you check "yes", please give date of conviction and specify crime.

SUMMARY OF EDUCATIONAL BACKGROUND:

How many years have elapsed since the date you were last a full-time student? _____

	Name	City & State	Dates	Curriculum Major	Diploma / Degree	Year Graduated
High School						
College / University						
Professional or Graduate School						



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WORK EXPERIENCE:

Dates	Employer & Location	Duties / Skills Acquired

SPECIAL SKILLS, INTERESTS, HOBBIES OR OTHER EXPERIENCES: Please indicate any skills, interests, hobbies or experiences outside of work that you feel will aid you during the year of training. (Please note this is in addition to the letter of interest required with this application.)

RECOMMENDATIONS

Please indicate the 3 individuals from whom you will obtain recommendations. Recommendations from faculty, professional or business associates should be sent to the program (address below) prior to the application deadline. Recommendations from science-oriented individuals who could address themselves knowledgeably as to your potential for successful completion of this program are preferable. Recommendations should be provided on DMC-University Laboratories Cytotechnology Program Evaluation Form.

	NAME	ADDRESS	CITY, STATE AND ZIP
1.			
2.			
3.			

I understand that if I am accepted as a student, I obligate myself to remain in training for the twelve (12) consecutive months. I will then be eligible for the American Society of Clinical Pathologists Registry Examination in Cytotechnology. I agree to take this examination.

I certify that I meet the pre-requisites for DMC-University Laboratories Cytotechnology Program as listed in the Instructions for Application and the information I have given on this application is correct and complete to the best of my knowledge. I authorize the investigation of all information I have given, including references. I understand and agree to fulfill my responsibilities as a student as described in program materials. I understand that the program may require a physical examination, evidence of health insurance, TB testing, and Hepatitis B immunizations, background check and/or drug screen prior to my final admission into the clinical year.

DATE: _____ **SIGNATURE:** _____

DMC-University Laboratories Cytotechnology Program adheres to equal opportunity practices. No applicant will be denied entrance on the basis of race, color, creed, national origin, sex, marital status, height, weight, age or handicap. However, with respect to handicap, the handicap must not be such that it would, even with reasonable accommodation, in and of itself preclude the student's effective participation in the program.