Carle Foundation Hospital

X1254A-0111

Carle Foundation Hospital

Cytotechnology Program Application

AN AFFILIATION OF THE UNIVERSITY OF NEBRASKA MEDICAL CENTER SCHOOL OF CYTOTECHNOLOGY

611 West Park Street, Urbana, Illinois 61801 (217) 383-3554
Educational Coordinator: Travis Blunier

Deadline for all application material: May 1

Please type or print in ink

Social Security Number _____–_____–_____ ❑ Female ❑ Male

Name _____ Former Name(s) _____
Last First Middle (if any appear on records)

Current Address _____
Street City County State Zip Code

Permanent Address _____
Street City County State Zip Code

Current Phone (_____)_____ Work Phone (_____)_____

Permanent Phone (_____)_____

Birthdate _____/_____/_____ Birthplace _____ Hometown _____
City/State City/State

❑ Parent(s) ❑ Guardian(s) Name _____
Last First Middle

Address of
Parent or Guardian _____
Street City County State Zip Code

Your e-mail address _____

NON-U.S. CITIZENS – please complete the following:

Country of Citizenship _____ Last Visa Classification _____

Arrival Date in U.S. _____

Permanent Residents, please list Alien Card number (Form I-151) _____

***UNITED STATES CITIZEN: PREDOMINANT ETHNIC BACKGROUND**

❑CAUCASIAN

❑ASIAN OR PACIFIC ISLANDER. Check Subcategory (A person of ❑Chinese, ❑Filipino, ❑Hawaiian, ❑Korean, ❑Vietnamese, ❑Japanese, ❑Indian or Pakistani, ❑Other Pacific Islander or Asian.)

❑BLACK. Not of Hispanic Origin (A person having origins in any of the Black Racial Groups.)

❑HISPANIC. Check Subcategory (A person of ❑Mexican, ❑Puerto Rican, ❑Cuban, ❑Central or South American or other Spanish Culture or Origin, regardless of race.)

❑AMERICAN INDIAN or ❑ALASKAN NATIVE Check appropriate category.
(A person having origin in any of the original peoples of North America.)

*** Supplying this information is optional with the applicant and is NOT a requirement for admission. The data is used by the U.S. Departments of Health and Human Services and Education for statistical purposes.**

Give chronological record of previous part-time or full-time employment:

Name of Employer Address Type of Position Held Inclusive Dates

_____

_____

_____

_____

_____

NAME ALL EDUCATIONAL INSTITUTIONS ATTENDED

List in chronological order the high school of graduation and ALL colleges, universities, professional, technical or business schools ATTENDED (even if no credit has been earned) on either correspondence, evening or daytime schedules. Begin with high school of graduation.

High School _____ Location _____
City State County

Date Graduated _____
Month Year

College, University, Professional, Technical or Business Schools Attended	City	State or County	Dates				No. of Hours Earned	Cumulative Grade Point Average (college only)	Program Degree or Certificate Received or Expected	Date Received or Expected	
			Entered		Left						
			Mo.	Yr.	Mo.	Yr.				Mo.	Yr.

If your education has been interrupted, list in detail your activities during the intervening period. Also, indicate if you have been suspended or dismissed from a collegiate institution.

WORK IN PROGRESS

Please list all courses currently in progress and those which you plan to complete prior to your enrollment at Carle Foundation Hospital's Cytotechnology Program.

1. CURRENT ❑Fall ❑Winter ❑Spring ❑Semester ❑Quarter Year ____ ❑Summer

Name of Institution: _____

2. FUTURE ❑Fall ❑Winter ❑Spring ❑Semester ❑Quarter Year ____ ❑Summer

Name of Institution: _____

Dept. Name	Name of Course	Credit Hrs.	Dept. Name	Name of Course	Credit Hrs.

List extra-curricular interests and give number of years of participation in each.

List honors, awards (i.e., scholarships, etc.). Specify high school (HS) or college (C).

Please provide a narrative describing your interest in Cytotechnology, particularly stressing your professional career goals.

1. Have you previously applied to this Cytotechnology program? ❑YES ❑NO
   If Yes, indicate: Year (s) _____
2. Transcripts: Applicants must request official transcripts from EACH institution previously attended, regardless of credit earned. Transcripts must be sent from the Registrar to the Educational Coordinator at Carle Foundation Hospital.
3. References: Three (3) letters of reference should be sent directly to the Educational Coordinator at Carle Foundation Hospital.
4. Photograph: Attach one billfold size recent photograph with date taken and your signature written on the back.
5. Mail completed application to the Education Coordinator at Carle Foundation Hospital.

All materials submitted in support of your application become the property of Carle Foundation Hospital and cannot be returned or forwarded.

NOTE: Should you desire to arrange for a disability accommodation in conjunction with completing the application process, please contact Travis Blunier, Educational Coordinator at (217) 383-3554.

FOR ALL APPLICANTS: One of the objectives of Carle Foundation Hospital's Cytotechnology program and the University of Nebraska Medical Center is to recruit and retain persons of high moral and ethical character. In accordance with this objective, both institutions reserve the right to review a candidate's suitability for admission.

THIS APPLICATION IS VALID FOR ONE CALENDAR YEAR BASED ON DATE RECEIVED BY CARLE FOUNDATION HOSPITAL.

I certify that information on this application is complete, accurate and true; and I understand that any information given falsely or withheld may make me ineligible for admission and/or enrollment. I agree to abide by the policies and regulations of Carle Foundation Hospital and the University of Nebraska Medical Center. I will inform Carle Foundation Hospital of any change in my plans to attend.

_____ _____

Month Day Year Applicant's Signature