

REFERENCES (Please sign waiver option: see attached)

1. SCIENCE PROFESSOR _____ CLASS TAUGHT _____
ACADEMIC INSTITUTION/DEPT. _____ FULL ADDRESS _____

2. SCIENCE PROFESSOR _____ CLASS TAUGHT _____
ACADEMIC INSTITUTION/DEPT. _____ FULL ADDRESS _____

3. SCIENCE PROFESSOR _____ CLASS TAUGHT _____
ACADEMIC INSTITUTION/DEPT. _____ FULL ADDRESS _____

4. SCIENCE PROFESSOR _____ CLASS TAUGHT _____
ACADEMIC INSTITUTION/DEPT. _____ FULL ADDRESS _____

5. OTHER REFERENCE (EMPLOYER, OTHER) _____
ADDRESS _____

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.

ALSO, AT THIS TIME, PLEASE HAVE FORWARDED TO US YOUR HIGH SCHOOL & COLLEGE TRANSCRIPTS.

FRANCISCAN ST. MARGARET HEALTH 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 St. Margaret Health 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 St. Margaret Health has the same rights if I do not meet the obligations established by the Program. I understand that if placed at Franciscan St. Margaret Health, 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 I acknowledge that these rules may be changed, interpreted, withdrawn or added to at any time at the discretion of the facility.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.

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 _____