**UNIVERSITY OF ILLINOIS AT SPRINGFIELD**
**CLINICAL LABORATORY SCIENCE PROGRAM**

## Application for Admission

**PERSONAL** **Date: _____**

Name_____
Last First Middle

UNIVERSITY I.D. NUMBER (OR SOCIAL SECURITY NUMBER) _____

CURRENT ADDRESS_____

_____
City State Zip Code

PERMANENT ADDRESS_____
(If different from above)

_____
City State Zip Code

HOME PHONE_____WORK PHONE _____CELL PHONE_____

EMAIL ADDRESS:_____

**EDUCATION**
LIST ALL COMMUNITY COLLEGES, COLLEGES AND UNIVERSITIES ATTENDED (LIST MOST RECENT FIRST)

School City Major Dates Attended Hrs/Degrees Completed

_____

_____

_____

_____

_____I am a UIS Student. _____I have already applied to UIS. _____I will apply to UIS soon.

When and where have you observed in a clinical/hospital laboratory?_____
How many hours were you there?_____ (You can arrange this by calling your local hospital laboratory. Preference is given to applicants who have been to clinical laboratory.)

I AM APPLYING TO ENTER THE CLS PROGRAM: FALL_____(enter year)

____ I AM AN MLT/CLT & I AM INTERESTED IN DOING THE ARTICULATION PROGRAM

LIST ALL COURSES IN PROGRESS OR TO BE COMPLETED BEFORE THE TERM FOR WHICH YOU ARE APPLYING:

COURSE NUMBER AND TITLE CREDIT HOURS TERM ENROLLED

_____

_____

_____

_____

____ I UNDERSTAND THAT A CRIMINAL BACKGROUND CHECK AND DRUG SCREEN MAY BE REQUIRED BEFORE HOSPITAL ROTATIONS. IF A STUDENT IS INELIGIBLE FOR ROTATIONS, THE STUDENT CANNOT COMPLETE THE CLS PROGRAM. CALL THE PROGRAM DIRECTOR IF YOU HAVE ANY QUESTIONS.

**REFERENCES**

PLEASE LIST THE NAMES AND ADDRESSES OF TWO COLLEGE SCIENCE INSTRUCTORS OR ONE SCIENCE INSTRUCTOR AND ONE EMPLOYER WHOM WE CAN CONTACT FOR REFERENCES:

Name and Title_____

Institution & Address_____

_____

City State Zip Code

Name and Title_____

Institution & Address_____

_____

City State Zip Code

**GOALS STATEMENT**

**PLEASE ATTACH TO THIS APPLICATION A BRIEF DESCRIPTION OF YOUR EDUCATIONAL AND PROFESSIONAL GOALS.**

**To the best of my knowledge the information which I have provided on this application is true and complete. I grant permission for the program personnel to verify my academic history and my past work or studies, and release them from any liability resulting from such an investigation.**

Signature:_____ Date:_____

Return completed application & professional goals statement to:

Program Director
Clinical Laboratory Science Program
University of Illinois at Springfield
One University Plaza, MS HSB 314
Springfield, IL 62703-5407