



College of Health Sciences  
BioMedical Sciences Department

## MEDICAL LABORATORY SCIENCE APPLICATION for PROFESSIONAL STUDIES

NAME \_\_\_\_\_  
Last First Middle/Maiden

UWM STUDENT ID #: \_\_\_\_\_ LAST 4 DIGITS of Social Security #: \_\_\_\_\_  
(or entire passport number if no SS# )

DATE of BIRTH: \_\_\_\_\_

UWM E-Mail: \_\_\_\_\_ PHONE # : \_\_\_\_\_

CAMPUS ADDRESS \_\_\_\_\_  
Number & Street City State Zip

HOME ADDRESS \_\_\_\_\_  
(if different from above)

EDUCATION: Name of School Location Dates Attended Yr. Graduated

UNIVERSITY \_\_\_\_\_

JR. COLLEGE/TECHNICAL SCHOOL \_\_\_\_\_

HIGH SCHOOL \_\_\_\_\_

### IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

NAME \_\_\_\_\_  
Last First

ADDRESS \_\_\_\_\_  
Street City State Zip

PHONE ( ) \_\_\_\_\_

**EMPLOYMENT HISTORY:**

<u>Employer</u>	<u>Position Held</u>	<u>Dates Employed</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any previous clinical lab experience? \_\_\_\_\_ If yes, where? \_\_\_\_\_

What capacity? \_\_\_\_\_ When? \_\_\_\_\_

**I acknowledge that the information I have supplied in this application is correct and understand that any falsification of information on this form may be cause for rejection as an applicant. I understand that this application is not legally binding on me in any way, that I am not obligated to enroll in the clinical program to which I may be assigned and that after enrollment as a student I have the right to withdraw voluntarily from the program for personal reasons.**

**I also understand that, if accepted, and enrolled as a student, I shall be subject to dismissal from the program for poor scholastic and/or technical performance, criminal acts or proved charges of unprofessional conduct.**

**I further understand that acceptance by the clinical affiliate site will require me to obey all regulations affecting personnel within the clinical laboratory/hospital.**

**I have read the Essential Functions (non-academic requirements) and understand them. Any questions that I have concerning these Essential Functions and how they apply to me have been answered by the Program Director to my satisfaction. It is my belief that I can satisfy each of the Essential Functions based on my existing skills and abilities, or through the use of corrective devices.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date