

Committee on Medical Technology Education

APPLICATION FOR ADMISSION TO A CLINICAL EDUCATION PROGRAM:

Postmark Date: _____

Committee Decision: _____

Notice To Applicant: _____

Deadline for receipt of application and transcript - October 1

Accept

Reject

Deadline for receipt of references - October 15

Application Fee: \$30.00

Application Date: _____

Personal History

Name: _____
Last First Middle

Social Security No: _____

Present Address: _____
Street City State Zip Code

Phone: _____ Email: _____
(Area Code) Number

Permanent Address: _____
Street City State Zip Code

In Case of Emergency Notify

Name: _____
Parent/Closest Relative

Address: _____
Street City State Zip Code

Phone: _____
(Area Code) Number

HOSPITAL PROGRAMS

Mercy Medical Center-Sioux City, Sioux City, IA
Rapid City Regional Hospital, Rapid City, SD
Sanford USD Medical Center, Sioux Falls, SD
St. Luke's College, Sioux City, IA

EDUCATION

University/Colleges Attended:

Name	Location	Date Attended	Degree
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is/are your major(s)? _____

What is/are your minor(s)? _____

Will you have a BS/BA degree before entering the program? _____ Yes _____ No

Have you previously attended any professional, vocational or Medical Technology Program? _____ Yes _____ No
If yes, please indicate:

Honorary and professional organizations, scholarships and honors, college/university activities and offices held:

Are you a U.S. citizen? _____ Yes _____ No If No, what is your Alien Registration #? _____

If you are not a U.S. citizen, what is your VISA type? (please check)

_____ student _____ exchange visitor _____ permanent resident _____ other, specify _____

Professional or Work Experience:

Employer	Address	Position	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITAL PREFERENCE

Please list in order, from the list of participating Medical Technology Programs, your choice:

First Choice _____

Second Choice _____

Third Choice _____

Are there any of the participating programs you prefer not to attend? Please list them below:

Have you applied to any programs other than those on the list? _____

REFERENCES

Three reference forms are required from applicants. Two of the references are to be from college science professors or clinical laboratory science advisors and the third reference from a former/current employer.

List below three people from whom you plan to obtain a reference.

1. _____
2. _____
3. _____

Attached are three reference forms to be filled out by these people and returned to the address found on the back of this form. The deadline date for receipt of references is **October 15th**.

Do you wish these references to be confidential? _____ Yes _____ No

If "yes", then you should, but are not required, to sign the following statement:

I hereby waive, release and forgo my rights to access and/or inspection of any letters or recommendations written by the above persons in accordance with the Family Educational Rights and Privacy Act of 1974, as amended.

Applicant's Signature

TRANSCRIPTS

All applicants must submit an official transcript at the time of application:

In addition, please list here the courses now in progress and those planned for the remainder of the year.

In Progress:

Planned:

INTEREST

In the space below, please write a brief statement of your interest in Medical Technology and your expectations for the clinical year.

I certify that the above information is complete and correct.

Signature of Applicant: _____

COMTE programs adhere to fair practices relative to student recruitment, admission and matriculation processes. They do not discriminate with respect to age, sex, marital status, race, color, creed, national origin, or handicap, except those handicaps that may affect bonafide professional performance or academic standards.

Send all information to the following address. Please enclose the \$30.00 Application Fee.

COMMITTEE ON MEDICAL TECHNOLOGY EDUCATION
Renee Rydell, MBA, MS, MT(ASCP)
COMTE Coordinator
Sanford USD Medical Center
1305 W. 18th Street
Sioux Falls, SD 57117-5039

