Community Hospital
School of Medical Laboratory Science

Please Note: We do not have MLS student visa program in place for this year.

Application Process:

1. Complete every item of the application and your narrative. Send to the address below.
   (Submit a brief (1 page) personal narrative describing your interest in Medical Laboratory Science.)

2. Request electronic or paper college transcript(s) to be sent directly to:
   Diana Dingman, MS, MT (ASCP) SM
   Program Director-School of Medical Laboratory Science
   Community Hospital Central Laboratory
   901 MacArthur Blvd.
   Munster, IN 46321
   ddingman@powershealth.org
   219-703-2412

   NOTE: Application cannot be considered until all transcripts have been received.

Based on initial assessment the School may:

3. Contact you to schedule an interview.

4. Request a Criminal background check from your State Police Dept., send or forward the results electronically to ddingman@powershealth.org

5. Schedule an appointment with Powers Health Occupational Health Dept. for drug screen and immunization /medical history.

Non-Discrimination Disclaimer/Disclosure:

The Community Hospital School of Medical Laboratory Science is dedicated to the principle of non-discrimination and equal opportunity in every aspect of the program, including but not limited to application, applicant review, selection process, classroom, laboratory, and clinical training, evaluation and potential employment placement.

Community Hospital
School of Medical Laboratory Science

Date _____

Applicant Name _____
Last **First** **Middle** **Other/Maiden**

Current address _____
Street **Apt.**

_____
City **State** **Zip**

Telephone **Cell ( )** _____ **Home ( )** _____ **Work ( )** _____

E-mail Address _____ **Alternate e-mail** _____

Permanent address _____
Street **Apt**

_____
City **State** **Zip**

Education----- NOTE: We do not have MLS student visa program available for this year.

Name of College/University	**Address**	**Degree**

Please request electronic or paper transcripts to be sent directly *from each institution* to:
***or* submit sealed, official transcripts to:**

Diana Dingman, MS, MT (ASCP) SM
Program Director-School of Medical Laboratory Science
Community Hospital Central Laboratory
901 MacArthur Blvd.
Munster, IN 46321
ddingman@powershealth.org

NOTE: Application cannot be considered until all transcripts have been received.

Community Hospital
School of Medical Laboratory Science

Employment

Company	Address	Dates	Position	Reason for leaving
Laboratory Experience				

Emergency Contact Information

Name	Telephone	Relationship

References

Name	Address	Telephone	email	Relationship
Personal				
Academic				
Employer				

Attestation:

Read the following carefully before signing:

I hereby certify that all entries on this form and attachments are true and complete and I agree and understand any falsification of information herein, regardless of time of discovery, may be cause for dismissal from the program. I understand that all information on this application is subject to verification. I understand that my acceptance into the program is contingent upon satisfactory completion of a drug screen. If selected, I may be required to complete a medical examination including proof required immunizations and drug screen.

Community Hospital
School of Medical Laboratory Science

If selected, I will be required to comply with Community Hospital established policies, rules and regulations pertaining to the Standards of Behavior and conduct of employees and the care of patients.

In accordance with state and federal laws, I will be reference checked for a criminal history. History of felony conviction may disqualify me from the program within Community Hospital.

I have read the foregoing conditions and I agree and comply with the terms and conditions therein.

In addition, I authorize investigation of all statements contained in my application. I hereby authorize former employers and educational institutions, licensing boards and authorities, their officers, agents or employees to furnish any information concerning my previous employment record, job performance, education, and character, and hereby release them from liability for reason thereof.

Signature_____**Date**_____

Printed name_____

Social Security Number XXX-XX-_____

To Be Completed by Program Director

Transcripts Received _____

References Received _____

Narrative_____