

APPLICATION FOR ADMISSION
OLD DOMINION UNIVERSITY
SCHOOL OF MEDICAL LABORATORY
AND RADIATION SCIENCES
CYTOTECHNOLOGY PROGRAM

TYPE OR PRINT PLAINLY IN BLACK INK
(Deadline: February 1st)

Date _____

NAME _____
(Last) (First) (Middle)

SOCIAL SECURITY NUMBER _____
(Required of all applicants)

PERMANENT ADDRESS _____

MAILING ADDRESS _____

(If different from above)

TELEPHONE NUMBER () _____ () _____
Home Business

NAMES AND ADDRESS OF ALL HIGH SCHOOLS (S) / UNIVERSITY (S) ATTENDED
INCLUDING ODU. Request official records for each to be sent to:

**Program Director, Cytotechnology Program
Room 2118, Technology Building
Old Dominion University
Norfolk, VA 23529**

NAME ADDRESS MAJOR DATES ATTENDED DEGREE

LIST ALL CERTIFICATIONS OR STATE LICENSURES:

WORK EXPERIENCE: (List most recent first) – include volunteer work

<u>EMPLOYER</u>	<u>ADDRESS</u>	<u>JOB TITLE/DUTIES</u>	<u>DATES EMPLOYED</u> From / To
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REFERENCE REQUESTED FROM:

ALLIED HEALTH ADMISSION TEST (AHPAT) (OPTIONAL)

Date taken or planned: _____

WRITE A BRIEF STATEMENT OF YOUR FUTURE GOALS:

(Attach additional sheet as necessary)

I hereby apply for admission to the School of Medical Laboratory & Radiation Sciences in the discipline indicated at Old Dominion University. I understand that if accepted I must comply with all rules and regulations of the program and am responsible for becoming familiar with these. I hereby attest to the truth and completeness of all statements made by me on this application form. I understand that I may be disqualified from consideration or acceptance into the program in the event that any of the above statements made by me on this application are false.

APPLICATIONS AND ALL APPLICATION MATERIALS MUST BE RECEIVED BY February 1st

SIGNATURE: _____

DATE: _____

**OLD DOMINION UNIVERSITY
SCHOOL OF MEDICAL LABORATORY
& RADIATION SCIENCES**

Cytotechnology Applicant Evaluation Form

APPLICANT NAME _____ MAJOR _____

SOCIAL SECURITY # _____

NAME / TITLE OF EVALUATOR _____

ORGANIZATION _____

WAIVER OF ACCESS

I have chosen to have this evaluation statement remain:

- (A) _____ Confidential (B) _____ Not Confidential
(Candidate will not have access to confidential evaluations)

I understand that the School of Medical Laboratory & Radiation Sciences does not require me to execute this waiver and will review my application without regard to my choice.

Date _____ Signature _____

CANDIDATE SHOULD FILL OUT ALL INFORMATION ABOVE THIS LINE

Evaluator use this scale below as a guide to evaluate this applicant in the areas indicated. Place completed evaluation in an envelope, seal, and write signature across seal.

	Unable to Evaluate	Excellent	Above Average	Average	Below Average	Unsatisfactory
Academic Achievements						
Initiative						
Dependability						
Ability to Express Self						
Integrity						
Self Confidence						
Leadership Abilities						
Cooperation and Attitude						
Responsibility						

COMMENTS:

In what capacity is applicant known to you? _____

Signature _____

Please return to:

PROGRAM DIRECTOR, CYTOTECHNOLOGY PROGRAM
Room 2118, Technology Building
Old Dominion University
Norfolk, VA 23529

This evaluation must be received by this office no later than **February 1st** .