



Advancing Transfusion and Cellular Therapies Worldwide

Application for Admission Education Program for Specialist in Blood Banking Technology

Print or Type.

Submit two copies of this form to: SBBT Program [Address below]

Date: _____

Name of Institution: Community Blood Center/Community Tissue Services
Specialist in Blood Banking Technology Program

Address: 349 South Main Street, Dayton, Ohio 45402-2715

Medical Director: Ghada Khalife, M.D.

Classes beginning on: January 5, 2010

Name: _____ Social Security Number: _____

MT (ASCP) or BB (ASCP) Registry Number: _____

Street Address: _____

City, State, Zip Code: _____

Home Telephone Number: _____ Cell Telephone Number: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY *City and State*

Notify in case of Emergency: [Name, Address and Telephone Number]

United States Citizen? Yes No If No: Resident Student Visa

Name and Location of College or University	Date Attended		Degree	
	From	To	Title	Date

University Major: _____ University Minor: _____

Application for Admission (continued):

School of Medical Technology Attended: _____

Dates: From _____ **To** _____

Experience: Start with your most recent position. If you were ever employed in any position under a different name, give the name used in each position.

Company Name: _____ **From** _____ **To** _____

Address: _____
Number and Street *City and State* *Zip Code*

Supervisor: _____ **Reason for Leaving:** _____

Title/Duties: _____

Company Name: _____ **From** _____ **To** _____

Address: _____
Number and Street *City and State* *Zip Code*

Supervisor: _____ **Reason for Leaving:** _____

Title/Duties: _____

Company Name: _____ **From** _____ **To** _____

Address: _____
Number and Street *City and State* *Zip Code*

Supervisor: _____ **Reason for Leaving:** _____

Title/Duties: _____

Company Name: _____ **From** _____ **To** _____

Address: _____
Number and Street *City and State* *Zip Code*

Supervisor: _____ **Reason for Leaving:** _____

Title/Duties: _____

Application for Admission (continued):

Professional References: List three people from whom you who will request a letter of reference and completion of the **SBBT Program Application Reference Form.**

1. _____
Full Name *Street Address* *City and State*

Telephone Number *E-Mail Address* *Occupation*

2. _____
Full Name *Street Address* *City and State*

Telephone Number *E-Mail Address* *Occupation*

3. _____
Full Name *Street Address* *City and State*

Telephone Number *E-Mail Address* *Occupation*

Signature: _____ **Date:** _____

To Be Completed by CBC/CTS SBBT Program Administrators:

Name of Institution: Community Blood Center/Community Tissue Services
Specialist in Blood Banking Technology Program

Name of Program Director: Nancy Lang, MS, MT (ASCP) SBB

Accepted

Name of Education Coordinator: Nancy Lang, MS, MT (ASCP) SBB

Rejected

Date of Matriculation: _____

Signature of SBBT Program Medical Director: _____

One copy forwarded to Director of Education at AABB National Office: _____

Director of Education, AABB, 8101 Glenbrook Road, Bethesda, Maryland 20814-2749