

## Application for Admission Specialist in Blood Banking Technology Education Program

*Please print or type. Submit completed application to:*

Nancy Lang, MS, MT(ASCP)SBB  
 Community Blood Center  
 Specialist in Blood Banking Technology Program  
 349 South Main Street  
 Dayton, OH 45402-2715

**Application is for classes beginning in April 2012.**

**Name:** \_\_\_\_\_

**MT(ASCP) OR BB(ASCP) Registry Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
 \_\_\_\_\_

**Home Telephone Number:** \_\_\_\_\_

**Cell Telephone Number:** \_\_\_\_\_

**Preferred Email Address:** \_\_\_\_\_

**United States Citizen:**    YES    NO

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

**University Major:** \_\_\_\_\_ **Minor:** \_\_\_\_\_

**School of Medical Technology Attended:** \_\_\_\_\_

**Dates:** From: \_\_\_\_\_ To: \_\_\_\_\_

**Experience:** Start with your most recent position. If you were ever employed using a different name, please give the name used in that 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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Professional References:</b> List three individuals from whom you will request a letter of reference and completion of the <b>SBBT Program Application Reference Form.</b>			
1.	_____	_____	_____
	<i>Name</i>	<i>Street Address</i>	<i>City/State</i> <i>Zip Code</i>
	Telephone: _____ Email: _____		
	Employed by: _____ Job Title: _____		
2.	_____	_____	_____
	<i>Name</i>	<i>Street Address</i>	<i>City/State</i> <i>Zip Code</i>
	Telephone: _____ Email: _____		
	Employed by: _____ Job Title: _____		
3.	_____	_____	_____
	<i>Name</i>	<i>Street Address</i>	<i>City/State</i> <i>Zip Code</i>
	Telephone: _____ Email: _____		
	Employed by: _____ Job Title: _____		

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>This section to be completed by CBC SBBT Program Administrators</b>	
Signature of SBBT Program Director: _____	Date: _____
Signature of SBBT Medical Director: _____	Date: _____
<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected   Date of Matriculation: _____	