APPLICATION FOR ADMISSION

School of Medical Technology
Rapides Regional Medical Center
211 Fourth Street
Alexandria, LA 71301 Date: _____

[Please Print or Type]

Name: _____ Phone: _____

Current Address: _____

Home Address: _____

In Case of Emergency, notify: _____

Address: _____ Phone: _____

Relationship: _____

Class and Year Applying For: _____

CONDITION OF HEALTH
Be very detailed. If you have been hospitalized for anything, give record of dates and diagnosis. **Physical is not required.** (NOTE: Accepted applicants will be given a physical examination through the hospital.)

FORMAL EDUCATION

List schools and colleges attended indicating whether a degree or diploma was received.

ENCLOSURES:

*One copy of transcript DIRECTLY to Rapides Regional Medical Center.
*Two letters of recommendation – one from college advisor.
(Please have the evaluators use the forms supplied.)
*Health examination results.

REQUEST FOR PERSONAL RECOMMENDATION

Applicant's Name and Address: _____

_____

_____

TO THE EVALUATOR:
The above applicant is asking you to furnish a reference in support of their application for admission to the Rapides Regional Medical Center School of Medical Technology.

Would you please complete the following form to aid us in evaluating the applicant's potential.

Thank you very much for your assistance.

I. Student Rating

Characteristic	Excellent	Good	Average	Poor	COMMENTS
Intellectual Ability					
Practical Ability					
Motivation					
Initiative					
Interest					
Self-Expression					
Work Habits					
Emotional Maturity					
Reliability					
Adaptability					
Judgment					
Interpersonal Relationships					
Appearance					

REMARKS: _____

_____

II. Please check appropriate one(s).

A. Opinions are based on: Personal Information _____

Grades _____

Opinions of Others _____

None of the Above _____

B. Recommendation for this position:

1. Yes, with confidence and without reservation. _____

2. Yes, without reservation(s). _____

3. Yes, with noted reservation(s). _____

Comments: _____

_____

4. NO. _____

Evaluator's Name: _____

Please print

Title or Position: _____

Institution Address: _____

_____

_____

Phone: _____

SIGNATURE: _____

Mail to:

Rapides Regional Medical Center Laboratory
School of Medical Technology
211 Fourth Street
Alexandria, LA 71301

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