

# Application For Admission To: PRCC Medical Laboratory Technology Program

Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ PRCC ID #: \_\_\_\_\_ PIN #: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle) (Other)

Address: \_\_\_\_\_  
(Mailing Address)

\_\_\_\_\_  
(City) (State) (Zip) (County/Parish)

Date of Birth: \_\_\_\_\_ E-Mail address: \_\_\_\_\_ @ \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Sex: \_\_\_\_\_

\* Confidential information is requested on a voluntary basis. Refusal to provide this information will not subject the applicant to any adverse treatment, and the information will be used in a manner consistent with applicable Civil Rights Laws.

Pearl River Community College offers equal education and employment opportunities. The College does not discriminate on the basis of race, religion, color, sex, age, national origin, veteran status, or disability. For inquiries regarding the non-discrimination policies or to request accommodations, special assistance, or alternate format publication please contact Tonia Moody, Director of Admissions and Records, ADA/Civil Rights, and Title IX Coordinator, at P.O. Box 5537, Poplarville, MS 39470 or 601-403-1060.

High School Attended: \_\_\_\_\_ Graduation/GED Date: \_\_\_\_\_

### List all colleges attended below:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

### Emergency Contact:

Name (Last, First, Middle): \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I agree that the above information is true to the best of my knowledge and that deliberate falsification of information may result in denial of admission to the Medical Laboratory Technology Program at PRCC.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been convicted of a felony? Yes No

**Authorization for medical procedures:** In the event of serious illness or accident, every effort will be made to contact parents or guardian if student is under 21. In the event that delay in medical, surgical, or psychological treatment might be detrimental to the health of the student, authorization for consultation and treatment is required. Permission is granted to Pearl River Community College to refer this student for necessary treatment.

Date: \_\_\_\_\_ Signature of student (*If over 21*) \_\_\_\_\_

Date: \_\_\_\_\_ Signature of student or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**\*\*Please include an autobiography with your application \*\***

**Medical Laboratory Technology Program Autobiography -  
Why do you want to be an MLT?**