SINAI HOSPITAL
A LifeBridge Health Center

Stevenson University
Medical Laboratory Science

APPLICATION FOR ADMISSION: TRANSFER STUDENTS
BS IN MEDICAL LABORATORY SCIENCE

LEGAL NAME: _____
LAST FIRST MIDDLE

CURRENT MAILING ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

PHONE NUMBERS: (HOME) _____

(CELL) _____

EMAIL ADDRESS: _____

LETTERS OF RECOMMENDATION REQUESTED FROM: _____

INITIAL all statements below to attest to your understanding of the MLS Program policies.

____ *I understand the ADMISSION CRITERIA for the MLS program.*

____ *I believe I am capable of meeting the NON-ACADEMIC ESSENTIAL FUNCTIONS with or without reasonable accommodation.*

____ *I understand the MEDICAL REQUIREMENTS for the junior and senior years of the MLS program.*

____ *I am aware of the additional expenses incurred by a student in the MLS Program.*

____ *I understand that the completion of this application process does not guarantee admission to the program.*

____ *I am aware that the MLS program has only 10 total spaces per year.*

____ *I am aware that the MLS program has a limited number of clinical affiliates for clinical practicum rotations and a waitlist may need to be established for the full time students on the basis of GPA in MLS courses and successful progression in the program.*

____ *I understand the PROGRAM-SPECIFIC MLS PROGRESSION STANDARDS.*

_____ _____
STUDENT E-SIGNATURE OR SIGNATURE DATE