DEPT. OF HEALTH WORKFORCE
315 Falls Avenue • P.O. Box 1238 • Twin Falls, Idaho 83303
(208) 732-6310 • Fax: (208) 736-4743
(800) 680-0274 (in Idaho and Nevada)
https://workforce.csi.edu

APPLICATION FOR ADMISSION TO PHLEBOTOMY PROGRAM

Name _____
FIRST MIDDLE LAST FORMER NAME

Home Address _____
STREET ADDRESS CITY STATE COUNTY ZIP CODE

Permanent Address *(if different from above)* _____

Date of Birth _____ Home Phone: (AREA CODE) _____

Business Phone: (AREA CODE) _____ ☐ Male ☐ Female

EDUCATION

CNA or EMT State Certificate must be submitted with this application.

NAME OF SCHOOL	LOCATION OF SCHOOL	FROM MONTH / YEAR	TO MONTH / YEAR	DID YOU RECEIVE DIPLOMA? DEGREE? CERTIFICATE?	WHAT WAS YOUR MAJOR / MINOR?
HIGH SCHOOL OR GED					N/A
COLLEGE OR UNIVERSITY					

	TYPE	ISSUED BY WHICH STATE OR AGENCY	LICENSE NO.	DATE
Professional Licenses				
or Certifications				

FOLLOW UP INFORMATION

It is important that we follow up our students to be sure they obtain appropriate employment. Please provide information about two people who will always know where to locate you.

	NAME	MAILING ADDRESS	TELEPHONE NO.
1			
2			

HEALTH RELATED WORK EXPERIENCE AND/OR VOLUNTEER EXPERIENCE

Employer _____ Phone No. _____ Ext. _____

Address _____
STREET ADDRESS CITY STATE ZIP CODE

Supervisor's Name _____ Title _____

Dates Employed: From _____ To _____ Nature of Your Job Duties _____

Reason for Leaving _____ ☐ Full ☐ P art-time

Employer _____ Phone No. _____ Ext. _____

Address _____
STREET ADDRESS CITY STATE ZIP CODE

Supervisor's Name _____ Title _____

Dates Employed: From _____ To _____ Nature of Your Job Duties _____

Reason for Leaving _____ ☐ Full ☐ P art-time

REQUEST FOR REFERENCES — (TWO REQUIRED)

Student must contact these people to send letter of reference directly to director of program. DO NOT LIST PERSONAL FRIENDS OR RELATIVES. Use names of employers, counselors or teachers. Complete mailing address required on all names.

1	NAME	ADDRESS	PHONE
	OCCUPATION		EXT.
2	NAME	ADDRESS	PHONE
	OCCUPATION		EXT.

STATEMENT OF INTEREST

Please submit with this application a separate 300-500 word typed paragraph that details your interest in taking this phlebotomy program and why you should be selected.

PLEASE READ AND SIGN THE FOLLOWING

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misinterpretation or falsification of information is cause for denial of admission into the program I understand that illegal use, possession, and/or misuse of drugs are reasons for immediate dismissal from any of the programs in the Health Workforce Department.

_____ _____
SIGNATURE OF APPLICANT DATE

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Phone _____

Street Address _____ City _____ State _____ Zip _____