



List most recent employer first:

State work experience (please include Company Name and Supervisor with proper mailing address)

NAME OF EMPLOYER	ADDRESS (Street, City, State, Zip Code)	Type of Work	Dates	Reason for Leaving

Have you ever applied to or attended:

**Attendance Dates**

**Applied Only**

1. A school of surgical technology? \_\_\_Yes \_\_\_No \_\_\_\_\_ to \_\_\_\_\_ \_\_\_\_\_

2. A training program? \_\_\_Yes \_\_\_No \_\_\_\_\_ to \_\_\_\_\_ \_\_\_\_\_

Name of school \_\_\_\_\_

Address of school \_\_\_\_\_  
Street City State Zip Code

Reason for leaving: \_\_\_\_\_

**PERSONAL REFERENCES:** Give complete names and addresses of three persons - (not relative):

1. Name \_\_\_\_\_ Address \_\_\_\_\_  
Number and Street City, State, Zip Code

Occupation \_\_\_\_\_ Have Known for \_\_\_\_\_ Years

2. Name \_\_\_\_\_ Address \_\_\_\_\_  
Number and Street City, State, Zip Code

Occupation \_\_\_\_\_ Have Known for \_\_\_\_\_ Years

3. Name \_\_\_\_\_ Address \_\_\_\_\_  
Number and Street City, State, Zip Code

Occupation \_\_\_\_\_ Have Known for \_\_\_\_\_ Years

How did you hear about Choffin School of Surgical Technology? \_\_\_\_\_

Briefly describe in your own words what a Surgical Technologist does. \_\_\_\_\_

What personal skills and attributes do you possess that will enable you to complete this training? \_\_\_\_\_

**I understand the following statements:**

**Completing an application for admission to Choffin School of Surgical Technology does not obligate me or the school in regard to my admission. My application will be submitted for review to the faculty that comprise the Admissions Committee. If I am accepted, I will be notified by the school.**

**Any false information will void application. If already accepted into the program, immediate dismissal will result. This application will not be considered unless these statements have been read and signed by the applicant.**

**To have the opportunity for required clinical experiences and/or be hired for employment a criminal background check and drug screen may be required.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

TEST DATE \_\_\_\_\_ PASSED \_\_\_\_\_ FAILED \_\_\_\_\_ INTERVIEW (DATE) \_\_\_\_\_

MANUAL DEXTERITY \_\_\_\_\_ SCREWS \_\_\_\_\_ PINS & COLLARS \_\_\_\_\_ PDI-ODT \_\_\_\_\_

TRANSCRIPT:	Requested	Date received
High School	_____	_____
G.E.D.	_____	_____
College	_____	_____
Other	_____	_____

# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request that you release to Choffin School of Surgical Technology all information both oral or written regarding my records, character, conduct and performance.

I further release you from all liability which may result from furnishing such information.

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(applicant's signature)

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(date of signature)

Please note: You will not be considered for admission unless this authorization is signed.

Revised 1/10

## Accredited by

CAAHEP  
Commission on Accreditation of Allied Health Education Programs  
1361 Park Street  
Clearwater, FL 33756  
Phone: 727-210-3250  
Fax: 727-210-2354  
[www.caahep.org](http://www.caahep.org)  
and  
NCA-CASI

North Central Association Commission on Accreditation and School Improvement  
Marshall University  
100 Angus E. Peyton Drive  
South Charleston, WV 25303  
Phone: 1-800-525-9517  
Fax: 480-773-6905  
[www.advanc-ed.org/postsecondary](http://www.advanc-ed.org/postsecondary)

It is the policy of the Youngstown City Schools to offer educational activities, employment practices, programs, and services without regard to race, color, national origin, sex, religion, handicap, or age.