

UCSF Medical Center
Department of Laboratory Medicine
Clinical Laboratory Specialty Training Programs

Please print this application and mail it with all other required documentations to:
Joseph Musallam, UCSF Clinical Labs, 185 Berry St., Suite 290, Room 2132, San Francisco, CA 94107

APPLICATION FORM

APPLICATION DEADLINE:
1st week of December for March Session
1st week of May for September session of each Application Year

Prior to acceptance to the training program, each applicant must apply and receive Trainee license in the specialty for which she/he has applied for from California Department of Health Services, Laboratory Field Services, 850 Marina Bay Parkway, Bldg. P, 1st Floor, Richmond, CA 94804-6403, Telephone # (510) 620-3800

CHECK THE DESIRED TRAINING CATEGORY:

- | | |
|--|--|
| <input type="checkbox"/> Clinical Chemist Scientist | <input type="checkbox"/> Clinical Hematologist Scientist |
| <input type="checkbox"/> Clinical Immunohematologist Scientist | <input type="checkbox"/> Clinical Microbiologist Scientist |
| <input type="checkbox"/> Clinical Cytogeneticist Scientist | <input type="checkbox"/> Clinical Genetic Molecular Biologist Scientist*
(* Not Available Yet) |

PLEASE TYPE OR PRINT

DATE: _____

NAME: _____
(Last) (First) (MI)

SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____

(City) (State) (Zip Code) (Telephone)

ARE YOU A US CITIZEN? _____ IF NOT WHAT TYPE OF VISA? _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____
(Name)

(Address) (City) (State) (Zip Code) (Telephone)

Applications for positions to UCSF Clinical Laboratory Specialty Training Programs are considered without regard to race, color, creed, national origin, sex, age or handicap.

EDUCATION:

PLEASE LIST ALL COLLEGES/UNIVERSITIES YOU HAVE ATTENDED

(Official college/university transcripts must be sent to the education coordinator)

NAME	ADDRESS	MAJOR	YEARS ATTENDED	DEGREE/ DATE	GPA

PLEASE LIST SCIENCE COURSES CURRENTLY IN PROGRESS PRIOR TO YOUR GRADUATION:

COURSE TITLE	No. OF UNITS	COURSE TITLE	No. OF UNITS

LABORATORY EMPLOYMENT/EXPERIENCE:

PLEASE LIST LABORATORY EXPERIENCE/EMPLOYMENT, INCLUDING SUMMER OR VOLUNTEER WORK, YOU HAVE HELD IN THE LAST FIVE YEARS

EMPLOYER NAME	EMPLOYER ADDRESS	NATURE OF WORK	EMPLOYMENT DATES

Briefly describe your clinical laboratory experience:

PLEASE READ CAREFULLY BEFORE SIGNING:

Information given in this application process is true to the best of my knowledge. I understand any misrepresentation or omissions of facts may disqualify or terminate my application. I authorize investigation of all statements contained in this form as necessary to determine my eligibility for the Clinical Laboratory Specialty Training Program.

(Date)

(Signature of Applicant)

