



SIH Phlebotomy Program
Application

Welcome

Dear applicant,

Thank you for your interest in the SIH Phlebotomy Program.

Application Packet Contents

<input type="checkbox"/>	Application
<input type="checkbox"/>	Required Information
<input type="checkbox"/>	SIH Phlebotomy Program Tuition List
<input type="checkbox"/>	Background Check consent form
<input type="checkbox"/>	Non-Patient Photo Release Form

All items need to be completed and returned to:

SIH Outreach Laboratory in Marion

3117 Williamson County Parkway
Marion, IL 62959

Application

Application Information

The information listed below will be used only by the SIH Phlebotomy Program and is strictly confidential. Attach additional sheets if necessary. Please type or print clearly.

Name _____

Address _____

City/State/Zip _____ Social Security # _____

Telephone _____ Secondary Phone _____

Email Address _____

Education

High School _____ Address _____

From _____ To _____ Did you graduate Yes No Degree _____

College _____ Address _____

From _____ To _____ Did you graduate Yes No Degree _____

Other _____ Address _____

From _____ To _____ Did you graduate Yes No Degree _____

Application

Employment History

Employer 1 _____ Address _____
Telephone _____ Position/Title _____
Dates of Employment _____ Employment Status _____

Employer 2 _____ Address _____
Telephone _____ Position/Title _____
Dates of Employment _____ Employment Status _____

Employer 3 _____ Address _____
Telephone _____ Position/Title _____
Dates of Employment _____ Employment Status _____

Employer 4 _____ Address _____
Telephone _____ Position/Title _____
Dates of Employment _____ Employment Status _____

List your short term career goals

How did you learn about the SIH Phlebotomy Program

What benefits will you bring and/or take away from the program

Application

Background

Have you ever been convicted of a misdemeanor or felony (other than a parking violation) Yes No

If yes, explain _____

Note: Southern Illinois Healthcare requires a criminal background check prior to employment. A conviction will not automatically disqualify you from consideration for employment with Southern Illinois Healthcare.

Emergency Contact

Name _____

Address _____

City/State/Zip _____

Telephone _____ Relationship _____

Military Service

Branch _____ From _____ To _____

Rank at Discharge _____ Type of Discharge _____

If other than honorable, explain _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature

Date of Application

Required Information

Please attach copies to send with your packet

Illinois Driver's License

High School Diploma or GED Equivalent

Immunization Record

Must include — MMR, Varicella, Hepatitis B series**

Tuition Payment

Check made payable to SIH Phlebotomy Program

Tuition List

Description of Expense

Cost

Phlebotomy Course

8 weeks of lecture and 3 weeks of clinical work.

\$550.00

Textbook and Supplies included

Application and Certification Fee for American Society for Clinical Pathology (ASCP)

Upon completion of the program, students are eligible to apply for the ASCP National Exam. This exam is not a requirement, but students are highly encouraged to apply.

\$135.00

This fee is made payable to ASCP

If hired by SIH, reimbursement for testing expenses are possible.



- SIH Medical Group Center for Medical Arts
- SIH Medical Group Administration
- SIH St. Joseph Memorial Hospital
- SIH Medical Group Community Physicians
- SIH Memorial Hospital of Carbondale
- SIH System Office
- SIH Medical Group Hospital Physicians
- SIH Herrin Hospital

To be completed by applicant/employee

Last Name		First Name		Middle Initial
Maiden or Other Name				
Date of Birth		Social Security Number		
Sex	Race	Race Options (Asian, American Indian/Alaskan, Black, White, Unknown) Note: Enter White for Mexican or Latino.		
Driver's License #			State	
Current Address				
City		State	Zip	
Have you lived in any other state? If so, please list all cities and states you have previously resided in.				

Applicant authorization

1. Without reservation, I authorize this employer or any party or agency contacted by this employer to procure my consumer report and/or to obtain or furnish information concerning my credit, criminal, motor vehicle, employment or other history. I understand that inquiries may be made to various federal and state agencies, employers, references, acquaintances and others seeking information as to my personal characteristics, credit worthiness, employment status, general reputation, and mode of living.

2. Under provisions of the Fair Credit Reporting Act, certain information, when used for employment purposes, is considered to be a consumer report. This information includes, but is not limited to, public record information (criminal history, civil litigation, etc.), driving records, consumer credit history, education records, and employment records. If an adverse employment decision is made due, in whole or in part to information received as a result of these inquiries, I will be provided with a copy of the consumer report and a summary of my rights under the Fair Credit Reporting Act.

Print Full Name	
Signature	Date



Non-Patient Authorization for Photography, Video & Comments

Subject Name _____

Date of Birth _____ Phone _____

Address _____

City/State/Zip _____

I authorize SIH personnel to make, maintain and publish photographs, videos, digital recordings or written/audio recordings of myself and use such recordings in print publications, television, motion pictures, internet or other media, which will be circulated to the general public for marketing, business, educational or other purpose, or to provide access to members of the public media to do the same.

I release any and all rights or claims for payment or royalties.

I agree to release and hold harmless SIH, its trustees, agents, officers and employees from any liability related to the making of the above mentioned recordings.

Subject/Guardian or Subject's Personal Representative

Date

Personal Representative's Relationship to Subject (if applicable)

Witness

For office use only



Assistance Worksheet

All information provided will remain confidential

First Name: Last Name: Street Address: Apt#: City/State: Zip Code: County: Phone #(s): E-Mail Address: Birth Date:

Answer Yes or No to the following questions:

Veteran: Do you have a DD-214:

Disability: If Yes: Physical? Mental? Are you currently receiving or have you ever received Supplemental Security Income (SSI)?

Have you ever received Unemployment Benefits in the state of Illinois?

Are you currently or have you in the previous 6 months received Food Stamps/Link Card or have you lived with a family member who currently receives or received Food Stamps/Link Card within the last 6 months?

High School Dropout: Offender or Felon: Homeless:

Mark your highest grade level completed:

No GED/Diploma: GED: High School Diploma: Some College:

Other Post-Secondary Degree/Certification: Associate Degree: Bachelor Degree:

Please complete this section ONLY if you are between the ages of 16 and 24. Man-Tra-Con may offer incentives to those between the ages of 16 and 24 who meet eligibility requirements.

Age:

List the approximate month and year you last attended any school:

Please list the name of the last school attended:

Pregnant/Parenting: (Yes or No)