



CENTRAL SERVICE TECHNICIAN TRAINING PROGRAM APPLICATION

APPLICANT INFORMATION:

(print/type legibly, all items must be completed)

Last Name: _____ First Name: _____

Employee Number (County employees only): _____ Department: _____ Area: _____

Manger/Supervisor: Name: _____ Contact number: _____

ADDRESS:

Number and Street: _____ Apt. #: _____ City: _____ Zip Code: _____

Date of Birth: _____ Gender: F _____ M _____

Race/Ethnicity:

- American Indian or Alaska Native Asian Black or African American
 Hispanic or Latino Native Hawaiian or Other Pacific Islander White Two or more

CONTACT INFORMATION:

Email: _____ Phone #: _____ Emergency Phone Number: _____

DO YOU HAVE ANY PAID OR NOT PAID WORK EXPERIENCE IN ANY HEALTHCARE FIELD JOB? Yes___ No___

If yes, please explain the type of job and for how long

TELL US WHY YOU ARE INTERESTED IN THE CENTRAL SERVICE TECHNICIAN TRAINING PROGRAM:

PERSONAL/WORK REFERENCES:

Name: _____ Contact Number: _____

Name: _____ Contact Number: _____

Applicant's Signature: _____ *Date:* _____

<i>For Administrative use only. Received by:</i> _____	<i>Date:</i> _____	<i>Time:</i> _____
--	--------------------	--------------------