Ashley Lopez CST
Surgical Technology Program Manager
315 Falls Avenue HSHS Building
Twin Falls, Idaho 83301

Application for Admission
Surgical Technology Program

Name: _____

CSI Student Id Number: (required or SSN#)_____

Home Address:_____City_____State _____

Email address: _____

Home Phone (___)_____Cell phone (___) _____

EDUCATION
Transcripts will be attached to your portfolio

Name of school	Location of school	From Month/Year	To Month/Year	Diploma? Degree? Or Certificate	What was your Major?

Type issued by (state or agency) number date

Professional Licenses _____
Or certification _____

PREVIOUS WORK EXPERIENCE

Most recent employer	address	From Month/Year	Supervisor's name	Phone number	Nature of your duties

Emergency Contact Information

Please provide contact information for two persons who will always know how to contact you. This information is important in case of an emergency and for finding you if I need follow up information after you leave the program.

Name	Relationship	Address	Phone Number
1.			
2.			