

Medical Device Reprocessing Program Admission Request Form

First Name: _____ Last Name: _____

Street Address: _____ Apt./Unit#: _____

City/Town: _____ Province: _____ Postal Code: _____

Email: _____

Home Phone _____ Cell Phone _____

Gender: Female Male Other Gender Date of Birth (mm/dd/yyyy) _____

Student ID

Listed below are entry requirements to process this application. PROOF of attained credits must be attached.

Requirement	Name of attached supporting document or transcript
English: Grade 12 (C) or ENG4 or College English	

Signed: _____ Date: _____

mm/dd/yy

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

Personal information on this form is collected in accordance with sections 21, 39 and 49 of the Freedom of Information and Protection of Privacy Act and under the legal authority of the Ministry of Training, Colleges and Universities Act, R.S.O. 1990, and the Ontario Colleges of Applied Arts and Technology Act, 2002, Regulation 34/03, and may be used and/or disclosed for administrative, statistical and/or research purposes of the College and/or the ministries or agencies of the Government of Ontario and the Government of Canada. If you have any questions concerning the collection and use of personal information, please contact the Privacy Office at (416) 491-5050 extension 77846 or email privacyoffice@senecacollege.ca.

Faculty of Continuing Education OFFICE USE ONLY:

Date stamp and forward to:

Attention: Part-time Medical Device Reprocessing – Admissions