



**COLLEGE of  
CENTRAL  
FLORIDA**  
*-an equal opportunity college-*

**SURGICAL SERVICES  
PROGRAM APPLICATION**

**Date Submitted:** \_\_\_\_\_

**Legal Name:** \_\_\_\_\_  
Last First Middle (complete) Jr., etc.

**CF ID No.:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street/P.O. Box City

County State ZIP Code

**Home Telephone No.:** \_\_\_\_\_ **Cell No.:** \_\_\_\_\_

**Email (personal):** \_\_\_\_\_ **Email (Patriots):** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Telephone No.:** \_\_\_\_\_

**Did you graduate from high school?** ☐ Yes ☐ No **Do you have a GED?** ☐ Yes ☐ No

**Name of High School or GED:** \_\_\_\_\_

**Date of Information Session:** \_\_\_\_\_

**Civics Literacy Test?** ☐ Yes ☐ No **Test Date:** \_\_\_\_\_

**LIST ALL COLLEGES ATTENDED, REGARDLESS OF CREDITS EARNED, INCLUDING  
COLLEGE OF CENTRAL FLORIDA.**

College	Dates Attended	Degree

**I CERTIFY THAT ALL THE INFORMATION STATED ON THIS APPLICATION IS COMPLETE  
AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

**Applicant's Signature:** \_\_\_\_\_