



The Surgical Technology Program is three semesters: fall, spring and summer. Prospective students may apply for the program after completing all the pre-requisite courses listed below.

◆	Biol 190	Human Anatomy and Physiology	4 units
		- or -	
	Biol 260	Human Anatomy	5 units
◆	Medop 230	Medical Terminology	3 units
◆	College-level Reading (Reading 158 or proficiency on assessment test)		
◆	High school graduation in the U.S., GED or degree from a U.S. accredited college.		

If pre-requisites were completed anywhere **other than SWC**, you **MUST** complete the Pre-requisite Evaluation Request for Program Enrollment Form (contact SWC Pre-Requisites Department).

Complete applications are accepted in person, via fax , or US Mail and sent to Higher Education Center, Otay Mesa, 8100 Gigantic Street San Diego, CA 92154 Office 4401. Once application packet is submitted, it becomes our sole property. Please make copies of your records prior to applying. All interested applicants must apply during the annual application period.

COST:

The greatest direct expense is at the beginning of the first semester. Textbooks, enrollment fees, material fees, malpractice insurance and uniforms are the major cost items.

8100 Gigantic Street • San Diego, CA • 92154
(619) 482-6352 Office • (619) 216-6603 Fax
www.swccd.edu/nursing • email: nursing@swccd.edu



Southwestern College Surgical Technology Program

Student Application Checklist of REQUIRED Items

You will need **ALL** of the following items at the time of application.

- ☐ Complete Application (**submitted in person or US mail ONLY**)
- ☐ Unofficial transcripts must accompany application showing evidence of pre-requisites;
(including SWC) **OFFICIAL transcripts must be sent to the Admissions and Records office at 900 Otay Lakes Road Chula Vista, CA 91910**
- ☐ SWC ID Number (required at time of application)
- ☐ Copy of:
 - Social Security Card
 - Driver's License/State ID
 - CPR certification – Healthcare Provider from the American Heart Association
 - U.S. High School Diploma/GED or high school transcripts (**All foreign degrees must be evaluated by an agency prior to applying**)
 - Student Educational Plan (**SWC CURRENT STUDENTS: Must be program specific and preferably dated within 6 months at time of application**)
 - Immunization card/records and/or titers (lab work)
 - Pre-requisite Evaluation Request for Program Enrollment Form via Pre-requisite Office, if applicable (to clear external pre-requisites).
- ☐ Physical Examination Form with all immunizations completed
 - 2 MMRs or Titers for Measles, Mumps, Rubella
 - 2 Varicella or Titers (if you had the disease you must have titers)
 - 3 Hepatitis B or Titers
 - Tdap (within 10 years at time of application)
 - Flu (must be completed between October and November of each year)
 - 2-Step Intradermal TB Mantoux Test, Titers (Quantiferon TB) or chest x-ray within 5 years.
 -

Your immunization records or titer (lab work) results MUST accompany the application packet



Surgical Technology Program

Last Name: _____ First Name: _____ Middle: _____
If no middle name use NMN

Previous Name/Maiden Name: _____
Important if your records reflect a name different from above

Social Security Number: _____ Birth Date: _____ SWC ID # _____
(Required at time of application)

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____ *Email Address: _____
(*must provide valid email address)

High School or GED location name: _____ Graduation Year: _____

Have you previously applied to this Program? ☐ Yes ☐ No
If so, when? _____

Are you fluent in any language(s) other than English? ☐ Yes ☐ No
If yes, please list: _____

PREREQUISITES COURSES	Course Number	No. of Units	Lab Course	Year Completed	Name of College	Letter Grade Received
*Human Anatomy & Physiology OR Human Anatomy			Yes/No			
*Medical Terminology			Yes/No			
*College-level Reading			Yes/No			

****OFFICIAL** transcripts **MUST** be sent to SWC 900 Otay Lakes Road Chula Vista, CA 91910 **prior** to submitting your application.

8100 Gigantic Street • San Diego, CA • 92154
(619) 482-6352 Office • (619) 216-6603 Fax
www.swccd.edu/nursing • email: nursing@swccd.edu



PREVIOUS BACKGROUND IN HEALTHCARE

Have you had any formal education in other healthcare occupations? ☐ Yes ☐ No

If answer is yes, indicate type of program:

☐ RN ☐ Associate Degree ☐ Orderly ☐ LVN/LPN ☐ EMT/Paramedic
☐ Baccalaureate ☐ Certified Nurse Assistant ☐ Corps School ☐ Other _____

Name of School: _____ City and State: _____ Enrolled from: _____ to _____ Date Graduated: _____
month/year month/year

PREVIOUS WORK EXPERIENCE

<u>Agency</u>	<u>Position</u>	<u>From</u>	<u>To</u>

DO YOU HAVE A HOSPITAL SPONSOR? ☐ No ☐ Yes (please provide the following information)

<u>Name of Agency</u>	<u>Contact Person</u>	<u>Email</u>	<u>Phone Number</u>

8100 Gigantic Street • San Diego, CA • 92154
 (619) 482-6352 Office • (619) 216-6603 Fax
www.swccd.edu/nursing • email: nursing@swccd.edu



COMPLETE FOR STATISTICAL PURPOSES ONLY

Gender: ☐ Male ☐ Female
Age: _____
Ethnicity: ☐ African-American ☐ American Indian ☐ Filipino ☐ Non-Filipino Asian or Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Unknown ☐ Other: _____
Education: Highest Degree Completed: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated
U.S. Citizen? ☐ Yes ☐ No

To the best of my knowledge, the above information is truthful and accurate. The information submitted in this application packed it complete and accurate. I understand that falsification of any information on this application may be cause for non-selection or dismissal from the program.

Important: If you have a change in address, phone number or email, you must contact the Nursing Office by sending an email to nursing@swccd.edu. Your admission status will be compromised if we are unable to reach you. Please make copies of your complete application prior to applying to our program. Once your application is submitted to our office, it becomes sole property of the Nursing Department and we will not release or make copies of any documents. **Please initial** _____ (indicating that you have read and agree with this statement).

Applicant Signature: _____ Date: _____

For Official Use Only: ☐ Application Packet Complete ☐ Verified Social Security Card

8100 Gigantic Street • San Diego, CA • 92154
(619) 482-6352 Office • (619) 216-6603 Fax
www.swccd.edu/nursing • email: nursing@swccd.edu