College of DuPage

Continuing Education
Pharmacy Technician Program

Screening Form

Enrollment in the program is on a first-come, first-served basis until a cohort is filled provided students meet minimum admission requirements.

Complete this form and submit to:

Email: healthcare@cod.edu
Mail: College of DuPage
Continuing Education, Pharmacy Technician Program
425 Fawell Blvd., SRC 1110
Glen Ellyn, IL 60137-6599
In-person: Address above

Screening form must be submitted a week prior to the start of the first day of class for the spring semester, Jan. 22, 2024.

Last Name: _____ MI: _____ First Name: _____

COD Student ID# (if applicable): _____ DOB: _____

Daytime Phone: _____ Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

Educational History

High School Attended: _____ City: _____ State: _____

Graduation Date: _____ OR Date GED Received: _____

School/College/University: _____

Dates Attended: _____ Diploma/Degree Earned: _____

Selection Criteria

I have met the following minimum selection criteria (check all that apply):

☐ 18 years of age ☐ College Reading, Writing, and Math proficient

I have read and understand the information contained in this form. I have read and understand that submitting a screening form declares my intent to be considered for the Pharmacy Technician Program. I have read and understand the applicable licensure procedures, requirements and state laws of the pharmacy profession to ensure eligibility to receive a license for the completion of the program.

Signature: _____ Date: _____