



ALLIED HEALTH PROGRAMS APPLICATION FORM

Please write clearly, press firmly and be sure to complete all sections of the application.

IDENTIFYING INFORMATION

Last Name, First Name, Middle Initial, Street Address, City, State, Zip +4, Home Phone, Cell Phone, E-mail Address

Application for: Fall Year, Spring Year

Student ID

DEMOGRAPHIC INFORMATION (For Statistical Purposes Only; Not Used to Determine Admission)

Date of Birth, Gender, Residency Status, Ethnicity and Race

PROGRAM INFORMATION (Check One)

ALLEGHENY CAMPUS, BOYCE CAMPUS, SOUTH CAMPUS, BRADDOCK HILLS CENTER

EDUCATIONAL INFORMATION

HIGH SCHOOL, POST SECONDARY, High School Science Courses Taken in Last Five Years

IMPORTANT INFORMATION

Select clinical sites utilized in the health career programs may require pre-drug testing. Results of this testing may impact on student's ability to attend clinical and/or continue in a health career program.

VERIFICATION

I attest that the information on this application is correct to the best of my knowledge. Any falsification or misrepresentation of any information will be sufficient grounds for my dismissal or termination from the program.

Applicant's Signature, Date

NOTE: The College reserves the right to change requirements for educational or operational purposes.

Nondiscrimination Policy: The college does not discriminate based upon race, color, religion, national origin, ancestry or place of birth, sex, gender identity or expression, sexual orientation, disability, marital status, familial status, veteran status, age, or use of a guide or support animal because of blindness, deafness or physical disability of any individual.

White—Program Director, Yellow—Department Copy, Pink- Applicant retains for own records