

# Alumni Application for Admission

Bachelor Degree or Advanced Specialty Certificate Program

## Personal Information

Please complete all information. Please type or print clearly. Black or blue ink only.

Date of Application: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Gender (optional):  Male  Female Marital status (optional):  Single  Married  Divorced  Widowed

### LEGAL NAME

\_\_\_\_\_  
Last Name First Name Middle Name Maiden Name Previous Name(s)

### CURRENT CONTACT INFORMATION

\_\_\_\_\_  
Number and Street Effective until: Month/Day/Year

\_\_\_\_\_  
City State Zip Code Country County (if in Iowa only)

(\_\_\_\_\_) \_\_\_\_\_  
Home Phone: Area Code and Number Email Address, if available

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Work Phone: Area Code and Number Fax Number, if available Cell/Other Phone: Area Code and Number

### PERMANENT ADDRESS (if different than above address):

\_\_\_\_\_  
Number and Street City State Zip Code Country County (if in Iowa only)

### EMERGENCY CONTACT

\_\_\_\_\_  
Name (\_\_\_\_\_) \_\_\_\_\_  
Emergency Contact Phone: Area Code and Number Relationship to Contact

\_\_\_\_\_  
Number and Street City State Zip

## Academic Program Identification

### DEGREE PROGRAMS

Term beginning:  Fall 20\_\_\_\_  Spring 20\_\_\_\_  Summer 20\_\_\_\_ Will you be:  Full-time  Part-time (less than 12 hrs.)

Enter the number of the **program of study** from the list below: \_\_\_\_\_

#### Bachelor of Science

1. Allied Health Completion
2. Health Care Administration Completion
3. Nursing Completion (RN to BSN)

#### Advanced Specialty Certificate

4. Nuclear Medicine Technology

Please turn over

Do you plan to file for the current year Free Application for Federal Student Aid (FAFSA)?  Yes  No

Have you ever received special needs accommodations for educational purposes?  Yes  No

*(Disclosure of a disability is not a requirement for admission to the College or any of its programs but is required in order to receive academic and/or physical accommodations.)*

Do you have a record of founded child or dependent adult abuse?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been convicted of a crime in this state or any other state?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you completed the health care training that leads to licensure or a certificate as part of the admission requirement for you intended program?

Yes  No

Please list \_\_\_\_\_

\_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_