

Application Form

The Dermal Institute of Wisconsin

Please tell us about yourself

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alternate #: _____ Email: _____

Personal History

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: _____ Marital Status: Single _____

Married _____

Spouse's Name : _____ Number of Dependents: _____

How is your general health? _____

Do you have any physical disabilities? _____

Are you under a physician's care? Yes _____ No _____

Are you on any medications or substances? _____. If yes, please list _____

Education

Please circle last grade completed 8 9 10 11 12 13 14 15 16 Degree _____

Indicate if any of these apply: High School Diploma ____ Equivalency Diploma ____ College ____

Family Information

Father's Name: _____ Phone: _____ Address: _____

City/State/Zip _____

Mother's Name: _____ Phone: _____ Address: _____

City/State/Zip _____ Name of nearest relative: _____ Phone: _____

References

Please provide two references that we may contact:

I. Name: _____ Title: _____ Relationship: _____

Address: _____ City/State/Zip _____ Phone: _____

II. Name: _____ Title: _____ Relationship: _____

Address: _____ City/State/Zip _____ Phone: _____

General Information

How were you referred to the Dermal Institute of Wisconsin?

Why do you want to attend a school of aesthetics and how did you become interested?

What aspects of skin care interest you? Please rate your interests from 1 (most) to 8 (least).

Facials _____ Make-up _____ Nutritional Therapy _____ Massage _____

Waxing _____ Body Treatments _____ Equipment Usage _____ Aromatherapy _____

What do you expect your future salary to be as an Aesthetician?

Upon graduation: \$ _____ Two years after graduation: \$ _____

My Signature certifies that the above information is correct.

_____ Applicant's Signature Date

_____ Interviewer's Signature Date

Session Information

450-Hour Esthetics Training & Licensing Course

Full-Time Day _____ Part-Time Evening _____

Please enter start date of class: _____

Tuition

Amount Due: \$8,690

A non-refundable \$100 deposit must be sent in with this application form to reserve your space in class. Check enclosed _____

Please charge my credit card:

Credit Card Type _____

Card #: _____

Exp. Date: _____ CVV code: _____ Zip Code: _____

Name as shown on card: _____

If a student cancels the class and has paid by credit card, a 5% credit card fee will be deducted from their reimbursement.

Are you interested in setting up a payment plan? Yes _____ No _____

Please EMAIL or MAIL your completed form to:

The Dermal Institute of Wisconsin

ADDRESS: 5301 N Grandview Dr., Milton WI 53563

PHONE: (608) 449-4535

EMAIL: info@thedermalinstitute.org WEB: thedermalinstitute.org

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