ALL HEALTHCARE INSTITUTE

Application for Admission

Date application submitted: _____ Application for entry in Year: _____

Name_____
Last First Middle

Mailing address: _____

City: _____ State:_____ Zip code: _____

Phone#:_____ Alt Ph#:_____

E-mail_____

Citizenship Status: ☐ United States ☐ Other (Please specify) _____

Sex: ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married # of dependents: _____

Which group do you most identify with: ☐ American Indian
☐ Asian ☐ Black ☐ Pacific Islander ☐ White ☐ Hispanic

Can you provide proof of a high school diploma or GED certification? ☐ Yes ☐ No

School and location: _____ Date of diploma: _____

Do you have any other vocational/professional license? ☐ Yes ☐ No _____

School: _____ Date of graduation: _____

List your educational qualifications:

Name of Institution	City and State	Dates attended	Degree/Cert recd.

Please list any working experience:

Name of Employer	Dates of Employment

Do you have any chronic or recurring illnesses, emotional problems, or physical disabilities that might require special accommodations while in school or in clinical rotations? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Do you have a current CPR card from the American Heart Association?

☐ Yes ☐ No

(Proof of current CPR card is required for this program.)

Background Check

A criminal background check is required for enrollment in this program. Have you ever been summoned, arrested, taken into custody, indicted, convicted or tried for a violation of any law or ordinance or the commission of any felony or misdemeanor (including traffic violations)?

☐Yes ☐ No

If yes please explain below:

By Signing below you give us permission to run a background check on you.

Yes, I consent to the background check. Signature: _____

The information completed above is true and accurate to the best of my knowledge.

_____ _____

Date Applicant signature