# ADREEVA
## SCHOOL OF HEALTH PROFESSIONS
Advancing Knowledge to Improve Care

# APPLICATION FOR ADMISSION

Applying for Entry in: ☐ Spring (January) 202__ ☐ Summer (May) 202__ ☐ Fall (September) 202__

**ADREEVA School of Health Professions Programs:**

☐ Associate of Science in Applied Medical Sciences
☐ Associate of Science in Clinical Laboratory Sciences
☐ Diploma in Premedical Science
☐ Diploma in Clinical Laboratory Sciences
☐ Diploma in Pharmacy Technician
☐ Diploma in Phlebotomy Technician
☐ Certificate in Clinical Laboratory Sciences
☐ Certificate in Pharmacy Technician
☐ Certificate in Phlebotomy Technician

Applying as: ☐ New Applicant ☐ Re-Applicant ☐ Transfer Applicant

## A. PERSONAL DATA:

_____ _____ _____
Last Name/Family Name/Surname First Name Middle Name

Date of Birth (mm/dd/yy): _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

Country of Citizenship: _____ Country of Birth: _____

Country of Residence: _____ Passport No.: _____

Mailing Address: _____

City or Town: _____ State/Province/County: _____ ZIP Code/Postal Code: _____

Country: _____ Home Phone No.: _____ Cell Phone No.: _____

Email Address: _____

Permanent Address (if different): _____

City or Town: _____ State/Province/County: _____ ZIP Code/Postal Code: _____

Country: _____ Emergency Contact Person Name: _____

Relationship: _____ Phone No.: _____ Email Address: _____

Address: _____

## B. ADREEVA INFORMATION:

**How did you hear about ADREEVA School of Health Professions?** (Check all that apply)

☐ Internet search ☐ College Fair ☐ Advertisement (TV/Radio/Newspaper/Magazine) ☐ ADREEVA Admission Advisor ☐ Email from ADREEVA
☐ Seminar/Webinar ☐ Social Network ☐ Facebook ☐ Instagram ☐ Other: _____

## C. PERSONAL HISTORY:

a) Have you ever been convicted of a crime? ☐ Yes ☐ No If yes, please explain: _____

b) Have you ever been subject to a disciplinary inquiry by or before an oversight body? ☐ Yes ☐ No
If yes, please explain: _____

c) Have you ever been suspended or dismissed from an academic institution? ☐ Yes ☐ No
If yes, please explain and indicate which institution: _____

d) Have you ever attended University? ☐ Yes ☐ No Dates Attended: _____ If yes, please indicate: _____

e) Have you ever applied to ADREEVA before? ☐ Yes ☐ No If yes, when: _____

f) Was your schooling in English? ☐ Yes ☐ No If yes, which years? _____

g) How frequently is English spoken in your home? ☐ Never ☐ Rarely ☐ Often ☐ Always

h) What is your Ethnic Background? (optional) ☐Black, non-Hispanic ☐American Indian or Alaskan Native ☐Asian or Pacific Islander
☐ Caucasian, non-Hispanic ☐ Hispanic ☐ Other (please describe): _____

i) Describe your current Living Demographics? ☐ Urban ☐ Suburban ☐ Rural

j) State your Religion (optional): _____

## D. EMPLOYMENT, VOLUNTEER WORK AND EXTRACURRICULUR ACTIVITIES:

a) Do you have any academic experiences? ☐ Yes ☐ No If yes, please specify: _____

_____

b) List Volunteer Work in the last four years?

| Date | Description |
|---|---|
| | |
| | |
| | |

c) List all Extracurricular Activities?

| Date | Description |
|---|---|
| | |
| | |
| | |

c) Do you have any research experiences? ☐ Yes ☐ No If yes, please specify: _____

_____

c) List Publications / Awards / Honors?

| Date | Description |
|---|---|
| | |
| | |
| | |

## E. ACADEMIC RECORD DETAILS:

a) Please indicate your highest level of education: _____

b) Summary of Educational details:

| Degree/Diploma/Exam | Date Earned | Institution | Country | Grade/Mark Achieved |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If you have High School Diploma, O Level / CXC, Intermediate (10+2), WASSCE Please list all subjects:

| Subjects | Grade/Mark Achieved |
|---|---|
| | |

d) Test of English as a Foreign Language (TOEFL) or English Language Testing System (IELTS): Non-native speakers of English (Non-English Medium Education)

| Type of English Language Exam:<br>IELTS, TOSEFL-Paper, TOEFL-Computer, TOEFL-Internet | Test Date | Overall Score |
|---|---|---|
| | | |

## G. REFERENCES:

List two references (non-relatives) who can and will give an informed opinion of your capabilities and suitability for a career in medicine. These letters must contain their personal information for contact. Please inform them of your intention to apply. You may enclose their letters with this Application Form -

| Name | Address |
|---|---|
| | |
| | |

How do you plan to finance your studies?

☐ Loans ☐ Personal Savings ☐ Parents ☐ Others: _____

By submitting this form, I agree to be contacted by phone, email, or text about my education at ADREEVA School of Health Professions.

I, the undersigned, affirm the following:

_____ I understand that once my application has been submitted it may NOT be altered in any way.

_____ I certify that all the information in the application is my own work, factually true, and honestly presented. I authorize all schools attended to release all requested records and authorize review of my application. I understand that I may be subject to a range of possible disciplinary actions, including admission revocation or expulsion, should the information I certified be false.

_____ I understand that an offer of admission is conditional, pending receipt of final transcripts showing work comparable inquality to that upon which the offer was based.

A student's acceptance into the ADREEVA School of Health Professions is granted upon the presumption by the Admission Committee that (a) all courses currently being taken by the applicant will be completed prior to registration; (b) all statements made by the applicant during the admission process (oral, written or in submission of academic documentation) are true and correct. If it is subsequently discovered that false or inaccurate information was submitted, the university may nullify a candidate's acceptance or, if the student is registered, dismiss the student.

Signature of Applicant: _____ Date: ____/____/_____

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## PHYSICAL EXAMINATION AND IMMUNIZATION FORM

All incoming students must submit this completed, signed form **ALONG WITH APPLICATION FORM**.

Student's Name: _____ ADREEVA ID#: _____

Gender: ☐ Male ☐ Female ☐ Others: _____ Date of Birth (mm/dd/yyyy): ____/____/_____

Emergency Contact Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

**HEALTH INSURANCE: All students of ADREEVA are required to be covered by health insurance in Sierra Leone. Student will be charged for it along with tuition every semester.**

Do you now have or have you ever had:

| | Yes | | Yes | | Yes |
|---|---|---|---|---|---|
| Allergies / Asthma | ☐ | Epilepsy / Seizures | ☐ | Positive PPD Test/TB | ☐ |
| Cancer | ☐ | Gastrointestinal Disorder | ☐ | Psychiatric/Behavior Disorder | ☐ |
| Cardiovascular Disease | ☐ | Hepatitis/Jaundice | ☐ | Pulmonary/Lung Disease | ☐ |
| Diabetes | ☐ | High Blood Pressure | ☐ | Skin Problems/Disease | ☐ |
| Drug/Alcohol Abuse | ☐ | Kidney/Urinary Disorder | ☐ | Tobacco/Vaping use | ☐ |
| Endocrine Disorder | ☐ | Musculoskeletal Disorder | ☐ | Eating Disorder | ☐ |

Other illnesses/Comments (please explain any YES answers from above): _____

_____

Allergies: Yes or No. If yes, list all allergies: _____

Surgeries: _____

Previous hospitalizations: _____

Current medications: _____

### ATTENTION: UNDER EIGHTEEN (18) CONSENT TO TREAT

In order to provide routine and/or emergent care that may be necessary for students and at the same time to protect the providers and institutions involved, please complete and sign below:

I, _____ (parent/guardian) do hereby authorize the ADREEVA to consult medical and counseling staff of Sierra Leone to provide routine/emergent care to my son/daughter.

Name of Students: _____ Student's Date of Birth: ____/____/_____

Parent/Guardian Signature: _____ Date: ____/____/_____

## PHYSICAL EXAMINATION

This page must be completed, signed, and stamped by physician.

All incoming students must submit this completed, signed form **ALONG WITH APPLICATION FORM**.

Patient's Name: _____ ADREEVA ID#: _____

Height: _____ Weight: _____ BMI: _____ Temp: _____ BP: ____ /____ Pulse: _____ RR: _____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| HEENT | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Abdomen | ☐ | ☐ | |
| GU | ☐ | ☐ | |
| Extremities | ☐ | ☐ | |
| Neurologic | ☐ | ☐ | |
| Psychiatric | ☐ | ☐ | |

How long and on what basis have you known this patient? Months: _____ Years: _____ ☐ This visit only ☐ Professional basis

To your knowledge, does this patient have any significant medical problems? ☐ Yes ☐ No

Explain: _____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems? ☐ Yes ☐ No

Explain: _____

Do you know of any physical or psychological reason why this student would not be able to withstand the rigors of his/her program of study?

☐ Yes ☐ No Explain: _____

**IMMUNIZATION RECORDS:**

TB Status: _____ PPD Date Performed: _____/_____/_____ Results: _____

Date of Last Tetanus: _____/_____/_____ Diptheria: _____/_____/_____

MMR: _____/_____/_____ Hepatitis B: _____/_____/_____

Physician Name: _____ Phone: (_____) _____

Address: _____

Physician Signature: _____ Date: _____/_____/_____

Physician Stamp (REQUIRED):

| SUPPORTING DOCUMENTS |
| --- |
| ▪ Application fee: US $ 50<br>▪ Copy of biometric pages of Passport / National ID<br>▪ Copy of ID<br>▪ Passport size photos<br>▪ All Official Transcripts / Grade sheets<br>▪ Two (02) Recommendation Letters<br>▪ Police Record / Character Certificate<br>▪ Drug Screening Test (Marijuana, Cocaine, Opiates and Nicotine) |