

## RESPIRATORY THERAPY PROGRAM APPLICATION FOR ADMISSION



Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Previous Name (if different from above) \_\_\_\_\_

Current Address: \_\_\_\_\_  
Street

\_\_\_\_\_

City

State

Zip Code

Phone: Preferred ( ) \_\_\_\_\_ - \_\_\_\_\_ Secondary ( ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_ (preliminary contact will be made via email)

Citizenship (please check one): USA  Other

If other is checked, what is your residency status? \_\_\_\_\_

### **Optional Information**

Gender: Male  Female  Birthdate: \_\_\_\_\_

Family Status: Married  Unmarried

Number of Children: \_\_\_\_\_ Age(s): \_\_\_\_\_

Present Employment: (if any) \_\_\_\_\_

### **PRIOR EDUCATION**

List all High Schools, Colleges and Vocational Schools attended.

Name	Location	Dates	Degree/Certificate

Have you been enrolled in a health care program previously? Yes  No

If yes, what subject area? \_\_\_\_\_

**If yes, and in the last five years, please include a recommendation from that program of study.**

Did you complete the program? Yes  No

If not, please explain why. \_\_\_\_\_

---



---



---

**ACADEMIC RECORD**

Include **only college** work completed or in progress.

Course	College	Date	Grade/ P if in Progress
<b>BIOLOGY</b>			
Anatomy			
Physiology			
General Biology			
Microbiology			
<b>CHEMISTRY</b>			
Introduction to Chem.			
General Chemistry			
Organic Chemistry			
Biochemistry			
Chemistry for Health Science			
<b>MATHEMATICS</b>			
Algebra			
Calculus			
<b>ENGLISH</b>			
<b>PHYSICS</b>			
<b>PSYCHOLOGY</b>			

## MEDICAL/LEGAL INFORMATION

**All students will need a complete a physical prior to entering the clinical component of the program. The following disclosed information is for counseling use only. This information will remain confidential and will not be used in determination of program acceptance.**

Are there any current or previous conditions, illnesses, or medications which may affect your ability to meet the demands stated in the **Required Abilities Qualifications** document?

Yes  No

If yes, explain –

---

---

---

---

---

Have you ever been treated for any of the conditions below? If yes, place date.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Recurrent dizzy spells |
| <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Spinal defects         |
| <input type="checkbox"/> Rheumatic fever          | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Back problems          |
| <input type="checkbox"/> Tuberculosis             | Height _____                                 | Weight _____                                    |

Licensure requirements for Respiratory Care Practitioners require that you respond to the following questions. A yes to any of the below may not preclude you from obtaining an RCP license, it will be used for counseling purposes only.

*Background check / drug testing clearance is required of all students admitted into the program as a condition of their entry into the clinical setting.*

Have you ever had a conviction related to alcohol?  Yes  No

Have you ever been convicted for a drug violation?  Yes  No

Have you ever been arrested for a felony charge?  Yes  No

## GENERAL INFORMATION

Occasional evening and/or weekend educational or professional field trips may be required during the program.

Respiratory Therapy students are assigned course work and clinical activities removed from campus. The student will be expected to provide transportation to and from these assignments.

