

CHRP UNDERGRADUATE APPLICATION FOR ADMISSION
COLLEGE OF HEALTH RELATED PROFESSIONS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Return this form and a non-refundable application fee to: CHRP Admissions Office, 4301 West Markham, #619, Little Rock, AR 72205. The application fee is \$20.00 for the first program and \$10.00 for each additional program. Call the Office of Student Affairs for the latest information. Telephone: (501) 686-5730.

All sections must be completed to process the application.

PERSONAL INFORMATION

PLEASE PRINT

Date of Birth: Month/Day/Year

Social Security Number _____ - _____ - _____ / _____ / _____

Legal Name: Last/First/Middle _____

Other Names Under Which Transcripts Might Appear: _____

Birthplace _____ Citizenship _____

U.S. State of Legal Residence _____ Native Language _____

Reg. No. (If Permanent Resident Alien*) _____ Visa Type (If Non-Resident Alien*) _____

CURRENT MAILING ADDRESS: Street/City/State/Zip _____

_____ County/Parish _____

Home Phone () _____ Work Phone () _____

If less than six (6) months, indicate previous address: _____

PERMANENT MAILING ADDRESS: Street/City/State/Zip _____

_____ County/Parish _____

Home Phone () _____ E-mail Address _____

Have you ever been convicted of a felony? _____Yes _____No If Yes, please attach a separate sheet with an explanation.

FEDERAL AND STATE REPORTS REQUIRE THE FOLLOWING INFORMATION:

Male _____ Female _____ Are you Hispanic/Latino? Yes _____ No _____

Please select one or more of the following:

_____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ Native Hawaiian or Other Pacific Islander _____ White

*Non-resident aliens and permanent resident aliens or immigrants must provide proof of visa type with application.

ACADEMIC INFORMATION

CHRP PROGRAM FOR WHICH YOU ARE APPLYING (CHECK ALL THAT ARE APPLICABLE):

- | | |
|---|--|
| <input type="checkbox"/> Cytotechnology
<input type="checkbox"/> Dental Hygiene
<input type="checkbox"/> Little Rock <input type="checkbox"/> Mountain Home
<input type="checkbox"/> Diagnostic Medical Sonography
<input type="checkbox"/> Little Rock
<input type="checkbox"/> Texarkana
<input type="checkbox"/> Degree Completion (Already ARDMS Certified)
<input type="checkbox"/> Emergency Medical Sciences
<input type="checkbox"/> EMT <input type="checkbox"/> Paramedic
<input type="checkbox"/> Health Information Management (Medical Record Tech)
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
<input type="checkbox"/> Medical Dosimetry
<input type="checkbox"/> Medical Technology
<input type="checkbox"/> Traditional Degree Program
<input type="checkbox"/> MLT-MT <input type="checkbox"/> MT-Fstrk | <input type="checkbox"/> Nuclear Medicine Imaging Sciences
<input type="checkbox"/> Ophthalmic Technologies (Ophthalmic Medical Technology)
<input type="checkbox"/> Radiation Therapy <small>(Students must have earned 39 hours of Radiologic Imaging Sciences course work to apply for this program)</small>
<input type="checkbox"/> Radiologic Imaging Sciences (Indicate 1st, 2nd, 3rd preference)
<input type="checkbox"/> Fayetteville <input type="checkbox"/> Texarkana
<input type="checkbox"/> Little Rock
<input type="checkbox"/> Respiratory Care (Indicate 1st and 2nd preference)
<input type="checkbox"/> Little Rock <input type="checkbox"/> Batesville
<input type="checkbox"/> Texarkana
Note: Check one of the following for Respiratory Care:
<input type="checkbox"/> Traditional Degree Program
<input type="checkbox"/> Three-year Program Option
<input type="checkbox"/> RRT to BS
<input type="checkbox"/> Surgical Technology |
|---|--|

Semester you wish to enroll: Fall Spring Summer

Year you wish to enroll: _____ Have you ever applied to CHRP before? Yes No

DEGREE/CERTIFICATE SOUGHT (CHECK ONE):

Certificate Associate of Science Bachelor of Science Advanced Certificate

ARE YOU ATTENDING COLLEGE NOW: Yes No If Yes, where? _____

EDUCATIONAL INSTITUTIONS ATTENDED —List in Chronological Order (Last Institution First) All Colleges, Universities, or Other Post Educational Institutions Attended.				
Name of Institution (Do Not Abbreviate)	Dates Attended	Credits Earned Semester (S) or Quarter (Q) System	Credit System (Circle One)	Degrees/Certificates Earned (if any)
			S Q	
			S Q	
			S Q	
			S Q	
			S Q	

Return completed application and have each educational institution you attended send one official transcript to the address listed on the opposite side of this application. Transcripts issued to students are NOT acceptable. **NOTE:** Some departments/programs do not require high school transcripts (refer to latest CHRP catalog).

I hereby affirm that all information supplied on this form is complete and accurate. It is my understanding that I shall not be considered for admission to the University of Arkansas for Medical Sciences until I have submitted all credentials specified by the College and Department or Program. I understand that withholding information requested or giving false information will make me ineligible for participation in the program.

SIGNED _____

DATE _____