

UAMS Fay W. Boozman College of Public Health Application for Admission

Personal Information

- Name: Last _____ First _____ MI _____ Suffix _____
- U.S. Social Security Number ____/____/____ Hometown _____ 3. Sex Male Female
- Birthdate ____/____/19__ Birthplace _____ 5. Citizenship _____
- U.S. State of Legal Residence _____ Reg. No. (If Permanent Resident Alien) _____
- Current Mailing Address: Valid until (month/day/year) ____/____/20__
Home _____ Business _____
City _____ State _____ ZIP _____ City _____ State _____ ZIP _____
Telephone (____) _____ Telephone (____) _____
FAX (____) _____ E-Mail _____
- Permanent Address (if different from current address) _____
- Please mark the one race or ethnicity which you think applies to you best:
 - American Indian or Alaskan Native (Tribe: _____)
 - African American/Black (not of Hispanic origin)
 - Asian or Pacific Islander (includes the Indian sub-continent)
 - Hispanic/Latino (Spanish culture or origin, regardless of race)
 - White (not of Hispanic origin, having origins in any of the Native original peoples of Europe, North Africa, or the Middle East)
 - Race not included above, please specify _____Are you multi-racial or multi-ethnic (parents are of two or more of the above groups)? Yes No
If yes, please specify _____

The items concerning race, ethnic origin and sex will be used for reporting purposes only and will not be used in admissions decisions. UAMS is committed to the policy of providing educational opportunities to all qualified students regardless of their economic or social status, and will not discriminate on the basis of handicaps, race, color, sex, or creed.

Application Data

- Application is for entry in ____ Fall Term 20__ ____ Spring Term 20__ ____ Summer Term 20__ ____
- Degree Sought: DrPH Master of Public Health Certificate in Public Health Non-degree Master of Health Services Administration
- Dual Degree Program with _____
- Date of GRE, GMAT, or other approved test* (please specify) _____ List scores below, if known
GRE V ____ Q ____ A ____ GMAT Total ____ Other ____
%V ____ %Q ____
V ____ %V ____
- Date of TOEFL, if applicable. _____ Score. _____

- Applicants for the MPH or PBC program must provide names, complete addresses, and phone numbers of **THREE** academic or professional persons from whom you have requested a recommendation. An EXTERNAL REFERENCE FORM is REQUIRED for EACH and EVERY recommendation. Applicants for the DrPH program must provide names, complete addresses, and phone numbers of **FOUR** academic or professional persons from whom you have requested a recommendation. An EXTERNAL REFERENCE FORM is REQUIRED for EACH and EVERY recommendation. Applicants for the MHSA program must provide names, complete addresses and phone numbers of **TWO** academic or professional persons to serve as references. No external reference forms or formal letters of recommendation are needed for MHSA applicants.
All applicants must complete this section even if a resume or C.V. is enclosed.

- | | | | |
|--------------------|--------------------|--------------------|--------------------|
| 1. Name _____ | 2. Name _____ | 3. Name _____ | 4. Name _____ |
| Position _____ | Position _____ | Position _____ | Position _____ |
| Address _____ | Address _____ | Address _____ | Address _____ |
| _____ | _____ | _____ | _____ |
| Phone (____) _____ | Phone (____) _____ | Phone (____) _____ | Phone (____) _____ |

Educational and Professional History

15. List in chronological order all colleges, graduate and professional schools attended. If studies are not complete, indicate degree and date expected. **You must complete this section even if a resume or C.V. is enclosed.**

Institution & Location	Entrance Date: mo./yr.	Leaving Date: mo./yr.	Degree received or expected	G. P. A.	Field of Concentration

16. If applicable, please list courses which you are currently taking or expect to complete during this year. _____

17. Academic or professional honors or awards. (Please list and give dates.) _____

18. List all work experience, beginning with the most recent, including full-time and part-time. Attach sheet if necessary. **You must complete this section even if a resume or C.V. is enclosed.**

From Mo./Yr.	To Mo./Yr.	Position	Employer and full address	Supervisor

19. Please check all types of experiences in Public Health in which you have participated (if applicable).

PUBLIC HEALTH EMPLOYMENT

- | | | |
|---|--|---|
| <input type="checkbox"/> Environmental Engineer | <input type="checkbox"/> Biostatistician | <input type="checkbox"/> Public Health Laboratory Scientist |
| <input type="checkbox"/> Environmental Engineering Technician/Technologist | <input type="checkbox"/> Epidemiologist | <input type="checkbox"/> Public Health Laboratory Technician/Technologist |
| <input type="checkbox"/> Environmental Scientist/Specialist | <input type="checkbox"/> Public Health Physician | <input type="checkbox"/> Public Health and Community Social Worker |
| <input type="checkbox"/> Environmental Science Technician/Technologist | <input type="checkbox"/> Public Health Nurse | <input type="checkbox"/> Mental Health and Substance Abuse Social Worker |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Public Health Dentist | <input type="checkbox"/> Psychologist/Mental Health Provider |
| <input type="checkbox"/> Occupational Safety and Health Speciality | <input type="checkbox"/> Public Health Dental Worker | <input type="checkbox"/> Alcohol and Substance Abuse Counselor |
| <input type="checkbox"/> Occupational Safety and Health Technician/Technologist | <input type="checkbox"/> Public Health Veterinarian | <input type="checkbox"/> Mental Health Counselor |
| <input type="checkbox"/> Health Services Manager/Administrator | <input type="checkbox"/> Public Health Nutritionist | <input type="checkbox"/> Health Information Systems Specialist |
| <input type="checkbox"/> Public Health Policy Analyst | <input type="checkbox"/> Public Health Dietician | <input type="checkbox"/> Administrative or Clerical Staff |
| | <input type="checkbox"/> Public Health Attorney | |

PUBLIC HEALTH WORK ORGANIZATIONS

- | | | |
|--|--|--|
| <input type="checkbox"/> Official Public Health Agencies | <input type="checkbox"/> Private, Nonprofit Associations | <input type="checkbox"/> Personal Health Services Industry |
| <input type="checkbox"/> Other Public Sector Agencies that provide a Public Health service | <input type="checkbox"/> Community-Based Organizations | <input type="checkbox"/> Educational Institutions |

If yes to above, Local State Federal

20. If applicable, indicate the health profession(s) and state(s) in the United States in which you are certified, registered, or licensed to practice: _____

I hereby affirm that all information supplied on these blanks 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. I further agree to inform the College of Public Health of any change in my plans to attend the University of Arkansas for Medical Sciences. I understand that withholding information requested or giving false information may make me ineligible for admission and enrollment.

Signed _____ Date ___/___/20___