**APPLICATION FOR SELECTION TO PHYSICAL THERAPIST ASSISTANT**

HINDS COMMUNITY COLLEGE

1750 CHADWICK DRIVE • JACKSON, MISSISSIPPI 39204-3490 • 601-376-4800



Student I. D. Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_(or Last Four Digits of Social Security Number)\_\_\_\_\_\_\_\_\_\_\_

Home Telephone No. Cell Phone No.

Birth Date

**NOTE: Deadline for file completion – March 31st**

|  |
| --- |
| **Allied Health Programs****Office of Admissions****Nursing/Allied Health Center****1750 Chadwick Dr.****Jackson, MS 39204-3490** |

**INSTRUCTIONS**

1. Complete this form (PLEASE TYPE OR PRINT) and return to🡪
2. Request the registrar of each high school and college (except Hinds CC) you have attended to forward an original transcript from that institution to🡪
3. All notifications concerning admissions to the program will be made by mail and/or email.

**PERSONAL DATA**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Maiden Last

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street No. / P.O. Box / Route City State Zip

Physical Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street No. / Route City State Zip

Personal E-mail address and/or School E-mail address \_\_\_\_\_\_

**EDUCATIONAL DATA**

1. List all colleges and professional schools attended.

Name of School City and State Did you graduate? Dates attended

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ Yes ❒ No \_\_\_\_\_\_\_to\_\_\_\_\_\_\_

 mo/year mo/year

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ Yes ❒ No \_\_\_\_\_\_\_to\_\_\_\_\_\_\_

 mo/year mo/year

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ Yes ❒ No \_\_\_\_\_\_\_to\_\_\_\_\_\_\_

 mo/year mo/year

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ Yes ❒ No \_\_\_\_\_\_\_to\_\_\_\_\_\_\_

 mo/year mo/year

Notes: (1) Students must satisfy a criminal background check.  Individuals who have been convicted, pleaded guilty or pleaded no contest to certain felony crimes may be unable to attend clinical training or obtain employment in a licensed health care facility in Mississippi.  In addition, other felony and some misdemeanor charges may disqualify the student from participating in clinical experiences.  This includes, but is not limited to most felony charges, patterns of criminal charges, criminal charges within the past five years, no dispensation of charges, and pending charges. (2) Students are subject to random drug screens after admission.

***I certify that the statements in this application are true and complete to the best of my knowledge, and that I have attended no institution other than those listed therein. I am aware that falsification of information is a basis for denying admission or for immediate termination of enrollment.***

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**