

HCO-Registration Form ? Health Careers Office

Last Name		First Name		Initial	Preferred phone (cell?)
BANNER ID				Date form was completed	
Email Address		Campus Phone		Campus Box	
Concentration & Degree				Class Year	
Permanent address-Street		City (and Province) State		ZIP/Postal Code	
Country	Place of Birth	Citizenship	Home Telephone	Visa Type	

Parents or Guardian				
Name	Living?	Occupation	Residence	Education/College
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Ages of brothers	Ages of sisters	Your Secondary School	City, State	H.S. Graduation Year

Self Description—Optional				
Please tell us how you would identify yourself:				
African American <input type="checkbox"/>	Alaskan Native/ (tribal Affiliation) <input type="checkbox"/>	Asian American/ (country of family origin) <input type="checkbox"/>	Mexican American <input type="checkbox"/>	Other (specify) <input type="checkbox"/>
Black <input type="checkbox"/>	Native Hawaiian <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Chicano <input type="checkbox"/>	
Afro-Caribbean <input type="checkbox"/>	Pacific Islander <input type="checkbox"/>	Latino (country) <input type="checkbox"/>	Puerto Rican <input type="checkbox"/>	
American Indian <input type="checkbox"/>			White or Caucasian <input type="checkbox"/>	_____
Do you identify yourself as a disadvantaged applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you identify yourself as a first generation college student? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Institutional Action	
Were you ever the recipient of any action (Warning, Serious Warning, Dismissal, Suspension) by any college or medical school for:	
1. Unacceptable performance <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Conduct violations <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain on a separate sheet of paper.	

Applying for (check one only):		
<input type="checkbox"/> Medicine (allopathic and/or osteopathic)	<input type="checkbox"/> Veterinary	<input type="checkbox"/> MD/PhD
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Other (Specify) _____	