Armstrong Atlantic State University
Respiratory Therapy Department
Baccalaureate Program

Application for Admission

Term you plan to enter: Fall 20____

Social Security # (Last 4 digits): __________ Male: ____ Female: ____ Date of Birth:________________

Full Legal Name: ____
Last First Middle

Mailing Address: ____
Street City

____________________ ____________________ ____________________
County State Zip Code

Telephone & Email Information: **(Please Print Legibly!)**

Home:____

Work: ____

Cell: ____

Email: ____

State of Legal Residence: ________________________ Citizenship Status: ________________________

Place of Birth: ____________________ ____________________ ____________________
County City State

Marital Status: Single: ____ Married: ____ Other: ____

Emergency Contact: Please Print

Name: ____

Phone Number: Work ______________________________ Home ______________________________

Cell ______________________________

Have you ever attended a college, university or any other school beyond the high school level?
Yes ____ No ____

If yes, complete the information below. Please request an official transcript be mailed to the Office of the Registrar, Armstrong Atlantic State University, by each institution listed. **It is your responsibility to see that all transcripts are sent.**

Please list other names used previously, i.e. maiden name, previous married name, etc. ________________

____

Complete Name of School Location (City,State)	Attendance Dates From - To (mo/yr)	Graduation (yes/no)	Degree Rec'd.
Most Recent College			
________________________________	______________	_________	___________________
________________________________			
College			
________________________________	______________	_________	___________________
________________________________			
College			
________________________________	______________	_________	___________________
________________________________			

Applicant must have 2 Confidential Appraisal forms filled out and returned on his/her behalf. Forms must be sent directly to the Respiratory Therapy Department.

I certify that the information submitted in this application is complete and correct to the best of my knowledge and belief.

_______________________________________ ____________________
Signature Date

Please return to: Armstrong Atlantic State University
Respiratory Therapy Department
11935 Abercorn Street
Savannah, GA 31419-1997

CONFIDENTIAL APPRAISAL FOR ARMSTRONG ATLANTIC STATE UNIVERSITY RESPIRATORY THERAPY DEPARTMENT

I, ____,

(Please Print Your Name)

am applying to the Respiratory Care Program in the School of Health Professions. I am aware of the provisions of the Family Educational Rights and Privacy Act. I hereby authorize the release of the requested information directly to Armstrong Atlantic State University. I realize that I will not view or be informed of any portion of your reply. I desire that an objective evaluation be rendered.

____

Applicant Signature

	Superior	Very Good	Good	Fair	Poor	Unknown
Communication Skills						
Teamwork						
Personality						
Maturity						
Perseverence						
Reliability						
Initiative						
Intellectural Ability						

Considering this applicant's general qualifications for admission to the health profession, please rate him/her as:

☐ **Very Desirable** ☐ **Desirable** ☐ **Fairly Desirable** ☐ **Undesirable**

What contact have you had with this applicant and how well do you know him/her?

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Appraiser's Name (Please Print) ______________________________ **Signature:** ______________________

Title: ____________________ **Address:** ____

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Please do not return this form to the applicant. Mail directly to: Armstrong Atlantic State University, Department of Respiratory Therapy, 11935 Abercorn Street, Savannah, GA 31419-1997

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Title: ____________________ **Address:** ____

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