

APPLICATION FOR ADMISSION



SPARTAN HEALTH SCIENCES UNIVERSITY

SCHOOL OF MEDICINE
 SPARTAN DRIVE
 ST. JUDES HIGHWAY
 LA TOURNEY, VIEUX FORT
 ST. LUCIA, WEST INDIES

Telephone (758) 454-6128
 Facsimile (758) 454-6811
 Website: www.spartanmed.org

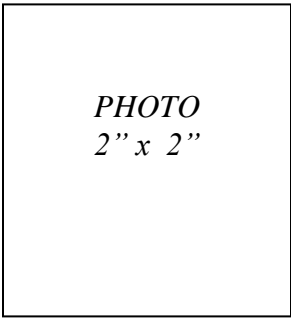


PHOTO
 2" x 2"

Please check: New Applicant ___ Re-Applicant ___ Transfer Applicant ___

Please check: Basic Sciences ___ Clinical Sciences ___

Entry Month: Jan ___ May ___ Sept. ___ Year _____

Personal Information

Name: _____
 Last First Middle

Social Security Number: _____

Birthdate: _____ Age: _____ Sex: _____
 mm/dd/yy

Birthplace: _____

Marital Status: _____ Married _____ Single No. of Dependents (including yourself) _____

Citizenship: _____
 Country

Passport Information (*As written on passport*)

Passport No: _____ Nationality: _____ Place of birth: _____

Date of Issue: _____ Date of Expiry: _____
 mm/dd/yy mm/dd/yy

Permanent Address

Mailing Address

Telephone:	Cell:	Telephone:	Cell:
Email Address:			

Education *List All Undergraduate & Graduate School (s) Attended:*

School Name	Location	Dates Attended		Major	Degree
		From	To		

List all Medical School (s) Attended:

School Name	Location	Dates Attended		Major	Degree
		From	To		

If employed, present position: _____

Professional License (s): _____

References

List two references (non- relatives) who can and will give an informed opinion of your capabilities and suitability for a career in medicine. These letters must contain their personal information for contact. Please inform them of your intention to apply. You may enclose their letters with this Application Form if you wish.

Name	Address	Business	Year Acquainted

Have you ever been convicted of any crime other than a minor traffic offense? ___ Yes ___ No If **Yes**, state the circumstances in detail on a separate sheet and attach it to this application.

Have you ever been involuntarily withdrawn from or dismissed by any college or medical school? ___ Yes ___ No If **Yes**, state the circumstances in detail on a separate sheet and attach it to this application.

How do you plan to finance your studies? ___ Loans ___ Personal Savings ___ Parents ___ Other : _____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN:

This application is incomplete until all required Supporting Materials listed below have been received. Completion is solely the responsibility of the applicant and only completed applications will be considered by the Admission Committee. Admission is granted on the basis of ability and promise in medicine. There is no discrimination on the basis of race, religion, national origin, skin color, ethnicity, age or gender.

I, the undersigned, do hereby apply for admission to Spartan Health Sciences University, School of Medicine. I accept full responsibility for all statements made and for all documents submitted in connection with this application except for whatever is provided by my references. I certify that these are true and complete according to my present knowledge and belief. I understand that I will be dismissed from the University after due process, without entitlement of any refund of tuition or other fees paid if it is discovered that any of said statements or documents are false or incomplete.

I also understand that I will be dismissed as said above if it is discovered that I habitually abuse drugs or fail to keep my person and my clothing clean and neat or behave in an unseemly or unprofessional manner. I also understand that I will be dismissed or placed on probation for poor or failing academic work or for failing to meet my financial obligations to the University or for failing to abide by the rules of any hospital, medical center or other institution where I am pursuing a course for which I am enrolled.

Signature of Applicant _____

Date Signed: _____

REQUIRED SUPPORTING MATERIALS (not applicable to re-applicants)

- Non –refundable US \$100.00 application fee payable to:
Spartan Health Sciences University (payments accepted by personal check, cashier’s check or international money order only –
(NO U.S. POSTAL MONEY ORDER AND NO CASH))
- Four recent passport size photographs (2x2 inches)
- A signed essay of your medical career expectations
- Two letters of recommendation
- Pre-Med Questionnaire
- Physical Examination and Immunization form
- Completed application form
- Official transcripts from all Undergraduate, Graduate and Medical school (s) attended
- Copy of Passport Information Page

**TO EXPEDITE MAIL SERVICE TO ST. LUCIA, SEND TO: P.O. BOX 989
SANTA TERESA, NM 88008
USA**



Questionnaire for Applicant

The following questions refer to the course and academic requirements established by Spartan Health Sciences University, School of Medicine in St. Lucia for entrance into the University. Please note that all required courses must be completed to be eligible for admission consideration.

Indicate by completing the appropriate box how you may have met or will meet the academic requirements. One year is equivalent to two semesters or three quarters.

Completed Courses

	Name	Number (s)	Grade (s)	Pending Completion
English *				
Biological Sciences **				
General Chemistry **				
Organic Chemistry **				
Physics **				
Mathematics *				

Have you taken the MCAT within the past 12 months? Yes ____ No ____ Score _____

It should not be inferred that admission is assured if these minimum scholastic requirements have been satisfied by the applicant.

Applicant's Name

Date

Applicant's Signature

Social Security Number

* 1 year or its equivalent

** 1 year including laboratory

Revised: March, 2008



SPARTAN HEALTH SCIENCES UNIVERSITY
SCHOOL OF MEDICINE

PHYSICAL EXAMINATION AND IMMUNIZATION FORM

Dear Doctor:

The bearer of this form has applied for admission to the above named University. The laws of the country in which it is located require that he/she had a physical examination within the past six months before admission can be granted. Please complete this form and return it to the applicant. You may use an equivalent form of your own if you prefer. (Completion of this form is at the expense of the applicant.)

I hereby certify that I am a physician duly licensed to practice medicine in _____
(state or country)

and that I have personally examined _____
(name of applicant)

I. Physical Examination:

Height _____ ft Weight _____ lbs

BP R Arm _____ L Arm _____ Pulse _____ Allergies _____

HEENT _____

Chest _____

Abdomen _____

Extremities _____

Genitalia _____

Mental Status _____

Condition (s) for which currently being treated _____

Please describe any uncorrectable disabilities in his/her perception, intellect, personality, communication, manipulation or ambulation that might limit or interfere with his/her educational participation with that of his/her classmates.

Other _____

II. Immunization Records

a) TB Status _____ PPD Date Performed _____ Result _____

b) Date of Last Tetanus Booster _____

c) Diphtheria _____

d) MMR _____

e) Hepatitis B _____

Name of Physician _____

Address _____

Telephone Number _____

Physician's Signature

Date

P.O. BOX 324, VIEUX FORT, ST. LUCIA, WEST INDIES •PHONE: (758) 454-6128 • FAX (758) 454-6811

E-mail Address: spartanmed@aol.com

Revised March, 2008