



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Have you ever been involuntarily withdrawn from or dismissed by any college or medical school?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: 418, Stanhope Street  
Brooklyn, NY 11237  
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



**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