## APPLICATION FOR PROGRAM ADMISSIONS

☐ Diagnostic Medical Sonography ☐ *Respiratory Care Science		*Radiologic Technology Medical Laboratory Technology		Emergency	Medical Science			
This application is for admission into the program		n beginning:	FALL		SPRING			
* NOTE: Applicants must cor	mplete remedial requi	irements & program pr	erequisites by the application	on deadline of the term	n for which admission is sought.			
Date of Application:			Student ID #:					
Full Legal Name:	Lost		First		Middle			
Current mailing address:	Last Street		FIISL		Midale			
	City			State	Zip			
Current telephone:	_( )		_ (where you can be		n 8 a.m. and 5 p.m. on weekdays)			
Email Address:			_					
If you have previously attended any school under a name other than that given above, please specify below:								
List other Allied Health Schools	/Programs you ha		): 		Date of Application			
PERSONAL INFORMATION  Male Female			Place of	Birth:				
Ethnic Origin: (OPTIONAL-for a  White Black	affirmative action   Hispanic Asian	N	Native American nternational	☐ Pr	efer Not To Answer			
Emergency Contact:								
Name					Relationship			
Street Address					( )			
City, State, Zip	0				Telephone			
Have you ever been convicted of violations (e.g. speeding or park If "Yes," provide a written explanation.	king violations)?							
Were you ever required to leave high school, college, graduate or professional school or ever denied readmission because of deficiencies either in conduct or scholarship? Yes No If "Yes," provide a written explanation.								
In order to provide better services for people with disabilities, the following voluntary information is needed. This is for affirmative action purposes. The information you provide will not affect your admission to the School of Health Sciences and will kept confidential. Please check all that applies to you: physical disability learning disability other disability Will you need accommodations in order to succeed in the program for which you are applying? yes no								

EDUCATIONAL BACKGROUND									
List the high school you attended a	nd REQUEST TI	HAT AN OFFIC	CIAL TRANS	CRIPT be sent the	e address :	shown below. *			
Last High School Attended:									
	City/State	G	Graduation Date						
Please list each college or university FROM EACH INSTITUTION SHOWING									
NAME OF SCHOOL	CITY		STATE	DATES ATTEN	IDED	DIPLOMA/DEGREE			
NOTE: If you have attended more than	three colleges, ple	ease list on a sep	parate sheet.		•				
Entrance exam (TASP, THEA, etc.) Services Building 956-295-3660 to arrange to		ssfully complete	ed prior to co	nsideration of this	applicatio	n. (Contact Testing Center, Student			
Date taken:	Or Scheduled:								
List all college or university COURS PRESENTLY APPEAR on your tran		e currently en	rolled or wil	l have completed	l before th	e program begins, that DO NOT			
COLLEGE OR UNIVERSITY	COURSE NO.		COURSE TITLE		CREDITHRS	T TERM/YR			
I understand that the Admission Committee will not regard this application as "complete" until all supporting papers have been received; therefore, it is to my interest to see that these are submitted as promptly as possible. It is also my understanding that official transcripts sent directly from each school I have attended must be received as soon as possible and at the end of each successive semester, quarter, etc., for as long as my application is being considered. (Transcripts showing additional work after acceptance must also be submitted.)									
If selected for admission to this program I will at all times conduct myself in accordance with the rules and regulations of the College, Program and its clinical affiliates. I certify that the information in this application is complete and correct and understand that the submission of false information is grounds for rejection of my application, withdrawal of any offer of acceptance, cancellation of enrollment, or appropriate disciplinary action.									
	Signature of Applicant				 Date				
If there are circumstances which may have an influence on your admission which you would like for those reviewing your application to know about, please									
describe on a separate sheet and attac		,	,		0,7	71			
DEADLINES FOR RECEIPT OF A	PPLICATION A	ND ALL REQU	IRED DOCU	IMENTS:					
PROGRAM		PROGRAM BEGINS			APPLICATION DEADLINE				
Emergency Medical Science		Fall Semester		June 15 2nd Friday of July (Noon)					
Medical Laboratory Technology Radiologic Technology		Fall Semester Spring Semester			Last working day of August				
Respiratory Care Science		Fall Semester			Last working day of May				
Diagnostic Medical Sonography						Last working day of May (Noon)			
* Application, transcripts, and supp	orting document	s should be hai	nd delivered						
Texas Southmost College									
ITEC Center 301 Mexico Blvd Ste H3A									
	Brownsville, Texas 78520-4993								
The Texas South	most College doe	s not discriminate	e based on se	x, race, color, nation					
Students please check one in this section. (Required Essential Functions can be found in Program Brochure)									
RADIOLOGIC TECHNOLOGY DIAGNOSTIC MEDICAL SONOGRAPHY MEDICAL LABORATORY TECHNOLOGY									

Students please check one in this section. (Required Essential Functions can be found in Program Brochure)

RADIOLOGIC TECHNOLOGY DIAGNOSTIC MEDICAL SONOGRAPHY MEDICAL LABORATORY TECHNOLOGY

I have reviewed and understand the required program essential functions and I believe that I meet all these standards.

I am not sure if I meet one or more of these functions and I need further evaluation. Check one or more the of the following:

Vision Speech and Hearing Fine Motor Function Psychological Stability