COLLEGE OF MEDICINE
&
HEALTH SCIENCES
SAINT LUCIA

Application Form

Please complete **ALL** sections of this application form and include 2 Passport Photo's. A $50 (US) Application Fee (non-refundable) must be submitted with this form. Checks made payable to**: "College of Medicine & Health Sciences".**

Include with your application a personal statement describing why you would like to become a Physician. Please also include your Curriculum Vitae (Resume) with the application if available.

Mail the completed Application Form and any other pertinent documents to**:**

College of Medicine & Health Sciences
U.S. Information Office
65 East Broadway
Butte, MT 59701

Phone: **406-533-6760**
Toll Free: **800-448-4008**
Fax: **406-782-2166**

Passport Photo

The Reverse of the Photograph Must be signed

Name: _____

☐ Doctor of Medicine (MD) Program

☐ Master of Science (MS) Degree In Clinical Anatomy

Personal Information:

Complete Legal Name: _____

Social Security Number/National ID Number: _____

Date of Birth: _____

Drivers License Number: _____ **Where Issued:** _____

Permanent Address: _____

City: _____

State/Province: _____

Country: _____ **Zip/Postal Code:** _____

Telephone Number: _____ **email Address:** _____

Marital Status: ☐ Single ☐ Married

Gender: ☐ Male ☐ Female

Country of Citizenship: _____ **Nationality:** _____

Emergency Contact

Name: _____

Address: _____

Telephone Number: _____ **Relationship:** _____

Have you ever been convicted of a crime? ☐ Yes ☐ No

Have you ever been suspended, dismissed or forcibly withdrawn from an educational institution?

☐ Yes ☐ No

Educational Information:

Type of Admission: ☐ New Applicant ☐ Transfer Applicant

MCAT Taken? (Not Required): ☐ Yes ☐ No

Date MCAT taken: _____

MCAT Score: _____

Overall Grade Point Average: _____ **Science Grade Point Average:** _____

College(s) attended:

1. School: _____

   City/State/Country: _____

   Dates: _____ Major: _____

   Degree(s) earned: _____

2. School: _____

   City/State/Country: _____

   Dates: _____ Major: _____

   Degree(s) earned: _____

3. School: _____

   City/State/Country: _____

   Dates: _____ Major: _____

   Degree(s) earned: _____

4. School: _____

   City/State/Country: _____

   Dates: _____ Major: _____

   Degree(s) earned: _____

Indicate courses you have completed below:

- ☐ Inorganic or General Chemistry
- ☐ Organic Chemistry
- ☐ General Biology or Zoology
- ☐ Advanced Biology and Chemistry
- ☐ Physics
- ☐ College-level Mathematics
- ☐ English

· Original Transcripts/Official Documents are required from all Colleges and Universities that were attended.

· For Transfer Students: If transcripts are unavailable or if more than four years have elapsed since course(s) were completed, a challenge examination may be required.

Which program best fits your needs?

1. ☐ Full-Time-On Campus MD Program
2. ☐ Online Independent Study MD Program (partial online for Healthcare Professionals)
3. ☐ Masters of Science (MS) in Clinical Anatomy (On-campus or Independent Study)

Please indicate your health care background if applicable:

1. Physician Assistant ☐
2. Nurse Practitioner ☐
3. Doctor of Podiatry ☐
4. Dentistry/Oral Surgery ☐
5. Chiropractic ☐
6. Doctor of Veterinary Medicine ☐
7. Doctor of Osteopathic Medicine ☐

Other (Please state): _____

Application processing fee:

A **$50** processing fee must accompany this form.

Check/Money Orders should be made payable to "**College of Medicine & Health Sciences"**.

How did you hear of College of Medicine & Health Sciences?

☐ COMHS (student, alumni, faculty) ☐ Career/Pre-Health Advisor

☐ Internet Search ☐ Google ☐ MSN ☐ Yahoo ☐ Other Search

☐ E-mail ☐ Campus Poster ☐ College/Career Fair

☐ Brochure/Flyer ☐ Other

Required Professional Recommendations:

List the name, address, telephone number, of three (3) Professionals that will be submitting recommendations in support of your application. These **required** recommendations may be sent with the application or separately.

1. **Name:** _____

Address: _____

Phone: _____

2. **Name:** _____

Address: _____

Phone: _____

3. **Name:** _____

Address: _____

Phone: _____

I attest to the accuracy of the statements made by me on this Application, and I understand by signing, any false statements or omissions may result in invalidation of my application or in dismissal from College of Medicine & Health Sciences.

Signature: _____ Date: _____

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STUDENT MEDICAL REPORT

To be completed by a licensed practicing physician and sent to the above address.

Student Name: _____

Student Age: _____ Gender: _____

Physician: Please complete the following:

Has the student had or currently experiencing any of the following diseases?

Allergy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Any Mental Illness	☐ Yes	☐ No
Any Communicable Diseases	☐ Yes	☐ No

Any other illness that may impact on his/her ability to successfully undertake Medical School:

_____

Additional comments: _____

Examining Physician: _____

Address: _____

Telephone: _____

Board Certification(s): _____

Physician Signature: _____ Date: _____