AMERICAN MEDICAL SCIENCES CENTER

225 WEST BROADWAY, SUITE # 115., GLENDALE CALIFORNIA 91204 TEL. (818)240-6900. FAX (818)240-6902

APPLICATION FOR ADMISSION

LAST NAME*	FIRST NAM	E* MIDDLE	NAME		SS#	DMV ID#	
/ / DATE OF BIRTH (MM/DD / YY) * COUNTRY OF BI					COUNTRY OF CITIZENSHIP*		
ADDRESS*	STREET		CITY		COUNTRY	ZIP CODE	
			EL V	<i>1</i> 🗆			
HOME PHONE*	EMERGENCY PHONE*		F□ M□ GENDER*		MARITAL STATUS*		
PRESENT EMPLOYER	STREET		CITY	COUNTRY	ZIP CODE WORK PHONE		
PREVIOUS EDUC	CATION*						
HIGH SCHOOL/COLLEGE/ PROGRA POSTSECONDARY/UNIVERSITY		PROGRAM	EDUCATIONAL LEVEL		LOCATI	ON GRE DAT	
PROGRAMS							
☐ DIAGNOSTIC MEDICAL ☐ ECHOVASCULAR TECH ☐ Vocational Nurse	HNOLOGY 720 HOURS /30			☐ GENERAL ABD		PHY 810 HOURS / 36 S / 32 WEEKS	WЕ
STATISTICAL DA	_						
☐ U.S. Citizen ☐ Resident Alien ☐ Hispanic ☐ Black (non-Hispanic)		panic)	☐ Non Resident Alien ☐ White (non-Hispanic)		☐ M-1 ☐ Other		
REFERENCE ADVERTISE (TV, PUB)	LICATION)						
NAME							
I	LAST	FIRST			PHON	ΙE	
Why do you want	t to enroll in our o	enter?*					
Do you like to help people?			☐ YES				
Do you have a medical background?			☐ YES				
Are you prepared	to work hard?		☐ YES	□NO			
PROSPECTIVE STU	DENT*				/_	/	
ADMISSIONS REPR	SIGNATURE .				DATE	/	
	SIGNATURE				DATE		

^{* (}Asterisk) Precedes the fields required and must be completed by Non Immigrant Prospective Student