APPLICATION FOR ADMISSION
Medical Assisting Technology Program
East Arkansas Community College
(870) 633-4480, ext. 270
(870) 633-7222 (FAX)

Please type or print:

Name:_____ _____ _____ _____
           Last   First   Middle   Maiden

Address: _____ _____ _____ _____
                   Street/P.O. Box   City   State   Zip Code

Phone: _____ _____ _____
                 Home   Work   Cell

Student ID #: _____ **E-mail:** _____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Please indicate type of admission sought:

_____ Initial Application   _____ Readmission   _____ Transfer

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

List all college/universities/technical schools attended. It is the student's responsibility to contact all of the institutions previously attended and request your **OFFICIAL** transcript be sent to **BOTH** the **Office of the Registrar and Department of Allied Health Science – Medical Assisting Technology Program**. Please use back of form, if more space is needed.

Note: Each transcript must be sent even if grades are recorded on another transcript. All transcripts must be mailed directly from the institution(s) to be considered official. All requested transcripts/information must be received by the application deadline.

_____
College   **Dates Attended**

_____
College   **Dates Attended**

_____
College   **Dates Attended**

I certify that the above information is accurate. Applicants who misrepresent/omit information from the application form become ineligible for admission or subject to dismissal after admission has been granted.

SIGNATURE: _____ **DATE:** _____