Application Form
Medics in Medicine Bridge Program
Trevecca Nazarene University
Physician Assistant Program

This form is a Word™ document in which you can type in your answers. Use as much space as you need to answer each question. Answer every question even if the answer is "no records/no information exists." Once completed, save a copy and then email an attachment to admissions_pa@trevecca.edu. This will facilitate opening a file for you. Because this form needs to be signed, print it, sign it, and then send a hard copy to PA Program – MiM Application, Trevecca Nazarene University, 333 Murfreesboro Road, Nashville, TN 37210. Applications are **due January 1st** of each year.

Name (First, Middle, Last): Indicate any alternate names. Examples of alternate names include maiden names, nicknames, or alternate spellings which may appear on official transcripts, test results, or how your references may address you in their letters.

Mr. Ms. Dr.	First	Middle	Last	Jr, Sr
Alternate				
Alternate				

Preferred mailing Address: Make sure that you have access to mail delivered to this address.

Street Address: ____

Apartment#/Building: ______________________________________

City: ______________________________ State: _____ 5 digit zip code: ________________

Telephone number: phone number where you can be contacted during regular business hours preferably with the ability to leave a voice message when you are not available:

Area code: __________ phone number: ______________________________

DEMOGRAPHIC INFORMATION:

Military Service

Military Service dates: _______________________________________

Dates serving as medic or corpsman: ___________________________________

Branch of the service: ____

Rank at discharge: ________________________________

Discharge status: ________________________________

Languages

Physician Assistant students interact with patients from many backgrounds. Indicate any language(s) other than English in which you feel comfortable conversing.

____

Gender: Please give one of the following responses

Male   Female   Do Not Wish to Answer

Date of Birth: (MM/DD/YYYY) _________________________

Birthplace

State/Canadian province: _____________________________

County: ____________________________________

Country of your birth: ____________________________________

Additional details: ____

Secondary (High School) Data

High School: ____

City: ____

State/province: __________________________________

Date of graduation: ________________________________

If you did not graduate from high school and instead passed the GED exam, please input "GED" for the high school name and the city where you sat for the exam.

Professional Registrations:

Any current professional certifications (CNA, CPR, etc) should be listed under "health related training." The registration section is referring to professional organizations you may belong to, for example, the American Academy of Physician's Assistants. You may add additional lines as needed.

____

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ACT:

Date of scheduled exam or date exam was taken (MM/DD/YYYY): ____________________

Scores must be within the last 5 years. Please give scores if available. However, official scores must be received by the program to complete your application. The reporting code for Trevecca Nazarene University for the ACT exam is 4016. A minimum composite score of 23 is required of all applicants.

Composite Score: __________

English: _______

Mathematics: ______

Reading: ______

Science: ______

Combined English/Writing: ________

College Credit/Course Work:

Applicants must have completed at least 21 semester hours of undergraduate instruction including English Composition 3 semester hours (required prerequisite) at an accredited institution of higher learning. List the course number, course name, credit hours, and final grade for all undergraduate courses completed.

College:			
Course Number	Course Name	Credit Hours	Final Grade

Military courses completed/Health Related Training:

In this section you should list any current professional certifications. List all professional training programs, dates attended and institution providing the training. Indicate if the institution was a regionally accredited academic institution such as a college or university. Also, indicate institutions that are not regionally academically accredited, such as a hospital or technical school. Finally list any training programs in which the only record is the certification itself such as basic life support.

Institution: ______________________________________

Date(s) of training (MM/DD/YYYY): ______________________________

Training: ____

Certificate: ____

Institution: ______________________________________

Date(s) of training (MM/DD/YYYY): ______________________________

Training: ____

Certificate: ____

Institution: ______________________________________

Date(s) of training (MM/DD/YYYY): ______________________________

Training: ____

Certificate: ____

Academic Record

Recipient of any academic action: (If you have been disciplined or placed on academic probation while attending an academic institution. Please explain its nature, the action taken, and the outcome. Please type "no records exist" if this does not apply.)

Institution: ____

Date(s) (MM/DD/YYYY): ____

Action taken: ____

Institution: ____

Date(s) (MM/DD/YYYY): ____

Action taken: ____

Background Record

Felony or misdemeanor conviction: (If you have been convicted of a felony or misdemeanor. Please provide a brief explanation (100 words) in the space provided. If you are convicted of a misdemeanor or felony prior to matriculation, it is your responsibility to IMMEDIATELY inform this program. Please type "no records exist" if this does not apply.)

Type of record: ____

Date(s) (MM/DD/YYYY): ____

Explanation:

Suspensions/Revoked: (If you have had any certification, registration, license or clinical privileges revoked, suspended or in any way restricted by an institution, state or locality. Please provide a brief explanation. Please type "no records exist" if this does not apply.)

Item revoked: ______________________________________

Institution: ____

Date(s) (MM/DD/YYYY): ______________________________________

Explanation:

PATIENT CARE EXPERIENCE

(Defined as experiences in which the applicant is directly responsible for a patient's care; for example: prescribing medication, performing procedures, directing a course of treatment, working on patients as an active EMT, etc.)

Institution: ____

Position: ____

Date(s) (MM/DD/YYYY): ______________________________________

Institution: ____

Position: ____

Date(s) (MM/DD/YYYY): ______________________________________

Institution: ____

Position: ____

Date(s) (MM/DD/YYYY): ____________________________________

OTHER HEALTH CARE EXPERIENCE

(Defined as roles in which the applicant is working in the health or a health-related field but is not directly responsible for a patient's care; for example, filling prescriptions, performing clerical work, delivering patient food, cleaning patient rooms, working as "candy-striper," etc.)

Institution: ____

Position: ____

Date(s) (MM/DD/YYYY): ____________________________________

Institution: ____

Position: ____

Date(s) (MM/DD/YYYY): ____________________________________

HEALTH CARE SHADOWING

(Name of the Physician Assistant, specialty, hours or dates spent shadowing (observing) this health care professional)

Name of PA: ____

Type of practice setting: ____

Institution: ____

Date(s) (MM/DD/YYYY): ____________________________________

Name of PA: ____

Type of practice setting: ____

Institution: ____

Date(s) (MM/DD/YYYY): ____________________________________

RESEARCH

(Research work you performed OUTSIDE of work you received credit for on your academic transcripts)

Research position: ____

Duties: ____

Institution: ____

Date(s) (MM/DD/YYYY): ___________________________________

AWARDS, HONORS, AND LEADERSHIP

(List any honors or awards received in your academic or military career. List positions of leadership you have held within the last 5 years)

Institution	Award	Date (MM/DD/YYYY

COMMUNITY SERVICE

(Volunteer work you have done OUTSIDE of the health field)

Service organization	How did you participate?	Date (MM/DD/YYYY

OTHER WORK EXPERIENCE

(Jobs you have held OUTSIDE of the health field in the last 5 years)

Company/Institution	Position and required duties	Date (MM/DD/YYYY

REFERENCE CONTACT INFORMATION FOR THREE INDIVIDUALS:

a. If you want to have references sent electronically, the following fields need to be completed: Reference's Title, Reference's First Name, Reference's Last Name and Reference's Email Address. The other fields do not need to be completed.

b. If you want to have references sent by paper Reference Form, the following fields need to be completed: Reference's Title, Reference's First Name, Reference's Last Name, Reference's Occupation, Reference's Street Address, Reference's City, Reference's State, Reference Zip and Reference's Daytime Telephone. You should leave the Reference's Email Address blank. Address and contact information may be the reference's work or office, it is not required that you report their home address.

Have each reference send a letter on your behalf that addresses your personal character, ability to succeed in this program, and future contributions to the health care profession. Letters should be on reference's letterhead.

Reference's Title: ________________

First Name: ______________________ Last Name: ______________________________

Position/Occupation: ____

Street Address: ____

State: _____ Zip Code: ______________________

Telephone: (area code – number xxx-xxx-xxxx): ________________________

Email Address: ____

Reference's Title: ____________

First Name: ________________ Last Name: ______________________

Position/Occupation: ____

Street Address: ____

State: _____ Zip Code: ______________________

Telephone: (area code – number xxx-xxx-xxxx): ________________________

Email Address: ____

Reference's Title: ____________

First Name: ________________ Last Name: ______________________

Position/Occupation: ____

Street Address: ____

State: _____ Zip Code: ______________________

Telephone: (area code – number xxx-xxx-xxxx): ________________________

Email Address: ____

RELEASE STATEMENT:

I give my permission for Trevecca Nazarene University to contact any school, government entity, or reference provided in this application for additional information.

Print your full legal name: ____

Signature: _____________________________________ Date: ______________________

Please include a short (500 word essay) with this form answering the question: What qualities do you possess that will make you an asset to the health profession as a practicing physician assistant as related to the University Mission: **"Trevecca Nazarene University is a Christian community providing higher education for leadership and service."**