

# APPLICATION FOR ADMISSION

I AM APPLYING FOR:  PATHWAY  CERTIFICATE  MASTER OF SCIENCE

I am applying for the  Spring  Fall  Summer  Winter term of 20\_\_\_\_.

\*Pathway is Summer start only \* Certificate is Winter start only

SSN: \_\_\_\_\_ Name: \_\_\_\_\_

Do you have educational material under any other name? If yes, please list.

\_\_\_\_\_

Preferred Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Country: \_\_\_\_\_ Primary Telephone Number: \_\_\_\_\_

Secondary Telephone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Gender:  Male  Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_

Have you served in the Armed Forces of the United States?  Yes  No

Have you applied previously to PCOM?  Yes  No

## \*How Do You Describe Yourself

Black (Non-Hispanic)  American Indian or Alaskan Native  Hispanic

White (Non-Hispanic)  Asian or Pacific Islander  Other Asian

## Citizenship

Are you a U.S. citizen?  Yes  No

If no, what is your residency status?  Temporary  Permanent

If no, list country of which you are a citizen:

\_\_\_\_\_  
\_\_\_\_\_

## References

List the name of one person, who will submit a letter of recommendation on your behalf:

Name: \_\_\_\_\_

Position & institutional agency, practice, or affiliation of reference: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

\* PCOM policy prohibits discrimination on the basis of age, race, color, national or ethnic origin, sex, sexual preference, religion, disability, or marital status. This policy applies in recruitment and admission of students, employment of faculty and staff, and scholarship and loan programs. This policy is also followed in the operation of all other programs, activities and services of the College.

## Education

List all colleges attended in reverse chronological order:

College: \_\_\_\_\_ Location (City, State): \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_

College: \_\_\_\_\_ Location (City, State): \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_

College: \_\_\_\_\_ Location (City, State): \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_

College: \_\_\_\_\_ Location (City, State): \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_

Overall Undergraduate GPA: \_\_\_\_\_ Graduate GPA: \_\_\_\_\_

Have you ever been placed on probation or dismissed for academic or disciplinary reason by a college or university?

Yes  No

If yes, please elaborate below:

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## Professional Experience (Minimum two years health care experience)

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Job Title: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Brief Description of Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Contact Name and Title: \_\_\_\_\_ Contact Telephone Number: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Job Title: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Brief Description of Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Contact Name and Title: \_\_\_\_\_ Contact Telephone Number: \_\_\_\_\_



## Professional Disciplinary Action History

Please answer each of the following questions by marking either YES or NO. If this section of the application is not completed, your application will be considered incomplete.

1. Have you ever had a professional license, certification or registration, in any state, cancelled, limited, suspended or revoked?  YES  NO
  
2. Have proceedings ever been instituted against you for cancellation, limitation, suspension, or revocation of your professional license, certification or registration by a state regulatory authority?  YES  NO
  
3. Have you ever been convicted, or is there now pending, any criminal prosecution against you that would constitute a misdemeanor or felony?  YES  NO
  
4. Have you ever appeared, or been requested to appear before any licensure board concerning any violation by you of any law, rule or regulation of any state, district, territory or province in the United States or Canada?  YES  NO
  
5. Have you ever had your hospital privilege revoked, reduced or otherwise restricted?  YES  NO
  
6. Have you ever been subject to proceedings by a professional society or association, or any licensing agency or regulatory authority of a formal complaint against you?  YES  NO
  
7. Have you ever been notified by a medical facility, professional society or association, or any licensing agency or regulatory authority of a formal complaint against you?  YES  NO

If you have answered YES to any of the above questions you must furnish full details on a separate sheet attached to this form. Answering yes to any of the above questions will not itself remove your application from consideration for admission. Falsification, or knowingly providing inaccurate or incomplete information to the above answers, will be considered grounds for immediate dismissal from the masters degree program.

## Verification of Authenticity & Release of Information

My answers to the questions in this application and associated materials are true, accurate and complete to the best of my knowledge. Any misrepresentation in these materials will be considered grounds for dismissal should I be accepted. A copy of this application, references, and/or other supporting documents shall be considered as valid as the original in granting permission to verify this information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Date Received: \_\_\_\_\_

Please send completed application to:

### **Philadelphia College of Osteopathic Medicine**

Office of Admissions  
4170 City Avenue  
Philadelphia, PA 19131

800-999-6998  
www.pcom.edu  
admissions@pcom.edu

(To be completed by Admissions Office)