Date Received
By:_________

APPLICATION FOR ADMISSION
Medication Assistant 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:** __________________________________

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Please indicate type of admission sought:

_____ Initial Application _____ Readmission

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

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 – Medication Assistant 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.

____
Nursing Assistant Program Attended **Dates Attended**

____
College/Universities/Technical Schools Attended **Dates Attended**

____
College/Universities/Technical Schools Attended **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:** ______________________

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