



**MASTERS OF HEALTH SCIENCE, PHYSICIAN ASSISTANT PROGRAM
SUPPLEMENTAL APPLICATION FOR ADMISSION**

Please print or type and answer each question carefully.

Biographical Information

Full Legal Name _____
Last First Middle Maiden

Under what other name(s) might documents be received? _____

*Age _____ *Date of Birth _____ *Place of Birth _____

*Social Security Number _____ *Race _____ *Sex Male Female

*INFORMATION NEEDED FOR STATISTICAL REPORTING TO THE DEPT. OF EDUCATION

Telephone number at which you can be reached between 8:00 am and 5:00pm _____

Home Telephone _____ Cell Telephone _____

Email _____

Permanent Address _____
Street City State Zip

Temporary Address _____
Street City State Zip

Preferred mailing address: Permanent Temporary

Legal residence in what county and what state _____
County State

Employed by _____

Occupation _____ Business Phone _____

Spouse/Guardian _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Home Telephone _____ Cell Telephone _____

List individual to contact in case of emergency _____
Name Relationship Phone Number

Street City State Zip

APPLICATION FEE \$40.00 I certify that all statements made in this supplemental application are complete and true. I understand that every student enrolling at South College agrees to abide by all policies and regulations of the College that may be found in the Student Handbook or in the College Catalog.

I understand and agree that providing false information on this supplemental application is just cause for my dismissal from South College.

Applicant Signature _____

Date _____

Admissions Officer _____

Date _____

Release

At the request of South College, I hereby release the aforementioned firm from any debts, claims, actions, causes of action, demands, suits, and all liabilities whatsoever both in law and in equity, which may result from participation in any telecast or still photography made by or produced by South college.

In doing so, I hereby grant South College the right to use my name, photograph, likeness, or voice in any production connected with the College.

I hereby represent and warrant that I am of full age and have every right to contract in my own name in the above regard. I further state that I have read the above authorization and release prior to its execution and that I am fully familiar with the contents thereof.

Student's Signature Date

Witness' Name Date

Witness' Signature

**This is a supplemental application.
Print this supplemental application and send it directly to:
South College
School of Physician Assistant Studies
3904 Lonas Drive
Knoxville, TN 37909**

**In order to officially apply to the program, please complete your application with CASPA at:
<http://www.caspaonline.org>.**

**Please send all transcripts directly to CASPA.
GRE scores are sent directly to South College (code: 1310)**