

**WICHITA STATE UNIVERSITY  
PUBLIC HEALTH GRADUATE CERTIFICATE PROGRAM**

**APPLICATION FOR ADMISSION**

(PLEASE TYPE OR PRINT CLEARLY IN INK)

Non-refundable application processing fee:

Domestic applicant	\$10
International applicant	\$15
Re-application Fee	\$5

**PERSONAL INFORMATION**

1. Legal Name: \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME OTHER NAMES USED ON RECORD  
My WSU ID# \_\_\_\_\_

2. Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Female Male Marital Status: Single Married

\*3. Asian, Pac. Island or Indian Sub-Continent (A)\_\_\_\_ American Indian or Alaskan Native (I)\_\_\_\_  
African –American, Non-Hispanic (B)\_\_\_\_ White, Non-Hispanic (W)\_\_\_\_  
Hispanic (H)\_\_\_\_ Other (specify) \_\_\_\_\_

4. Mailing Address:

\_\_\_\_\_  
STREET CITY STATE COUNTY ZIP

5. Permanent Mailing Address (if different from above):

\_\_\_\_\_  
STREET CITY STATE COUNTY ZIP

6. Home Phone Number: \_\_\_\_/\_\_\_\_ Business Phone Number: \_\_\_\_/\_\_\_\_

E-mail Address: \_\_\_\_\_

7. Are you a U.S. Citizen? Yes \_\_\_\_ No \_\_\_\_  
If not, are you a U.S. Permanent Resident? Yes \_\_\_\_ No \_\_\_\_

8. When do you plan to enter the Public Health Certificate program?  
Fall, \_\_\_\_ Spring, \_\_\_\_ Full-time \_\_\_\_ Part-time \_\_\_\_

9. How did you hear about the Public Health Certificate program? \_\_\_\_\_

\* Voluntary

## EDUCATION

List in reverse chronological order, college, university, graduate and professional schools you have attended.  
Transcripts should be sent directly to the WSU Graduate Office, 107 Jardine Hall, WSU, Wichita, KS 67260-0004.

NAME OF SCHOOL	LOCATION	DATES OF ATTENDANCE				DEGREE	MAJOR	GRADE POINT AVERAGE
		FROM	TO	MO.	YR.	MO.	YR.	

Academic honors \_\_\_\_\_

## WORK EXPERIENCE

How many years of health-related experience will you have by the time of your anticipated enrollment? \_\_\_\_\_

List work experience in reverse chronological order. (Attach additional sheets if necessary.) This section must be completed. A resume or curriculum vita should also be attached.

Check if health-related

NAME AND ADDRESS OF EMPLOYER	JOB TITLE AND DESCRIPTION OF DUTIES	DATES OF EMPLOYMENT	FULL-TIME OR PART-TIME

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

NOTE: WSU reserves the right to verify the information contained herein and your signature is accepted as approval to verify same.