VirginiaTech
Invent the Future

Office of Health Professions Advising
Student Registration Form

Date: _____

Last Name: _____ First Name: _____

Student ID: _____ ____ Female ____ Male

VA Tech Email Address: _____

Alternate permanent email address: _____

Transfer student: _____ Alum: _____

GPA: _____ Major: _____ Minor: _____

Date of graduation from Virginia Tech (mm/yyyy): _____

Expected date for application to professional school (mm/yyyy): _____

Academic Advisor's Name: _____

Advisor's e-mail address: _____ Advisor's phone: _____

Career plan (please check one):

____ Allopathic medicine	____ Chiropractic	____ Dentistry
____ Nursing	____ Occupational therapy	____ Optometry
____ Osteopathic medicine	____ Pharmacy	____ Physical therapy
____ Physician assistant	____ Veterinary medicine	____ Other

Local address: _____ Phone: _____

_____

Permanent address: _____ Phone: _____

_____

Education: List all colleges/universities and dates attended, starting with most recent

Dates Attended	Institution	Major	Degree (if applicable)