WALTON INTERNATIONAL SCHOLARSHIP PROGRAM

APPLICATION FORM

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Walton International Scholarship Program
Application Form

Part A: Personal Data

1. Full Name_____
   Surname/Family Name First Middle
2. Current mailing address:_____
   Number and Street

   _____
   City/Town State/Province Country

   _____Telephone:(_____)_____
   Postal Code Country Code City Code

   Email address_____

3. Citizenship:_____ Date of Birth:_____

   City of Birth:_____ Country of Birth:_____

   Passport Number:_____ Issued at:_____

   Sex: ❒Male ❒Female Marital Status: ❒Single ❒Married ❒Divorced

4. Religious Affiliation/Preference:_____

5. Have you ever visited or lived in the U.S.? If "yes," how long? Please explain:_____
   _____

6. Have you ever had or do you currently have a U.S. Passport or Visa to enter the U.S.?
   ❒Yes ❒No If "yes," please explain:_____
   _____

7. Health: ❒Excellent ❒Good ❒Fair ❒Poor *Please complete medical section of application form.*

Part B: Parental Data

8. Name of: ❒Parent ❒Legal Guardian ❒Other Relative

_____

Surname/Family Name First

_____

Number and Street City/Town

_____

State/Province Country

_____

Postal Code Telephone Number

Father's Occupation_____
Mother's Occupation_____
Estimated Total Family Income_____
Religious Affiliation_____

9. Names and addresses of any relatives or friends living in the United States:

Name Address Relationship

_____
_____
_____
_____
_____
_____
_____
_____

Part C: Academic Data

10. List in chronological order, from high school/secondary to the present, the schools and Universities you have attended.

School Location Dates Degree/Diploma

_____
_____
_____
_____
_____

Have you taken the required TOEFL (Test of English as a Foreign Language)? ❒Yes ❒No
If "yes," what was your score:_____

Indicate your level of English proficiency: Spoken ❒Excellent ❒Good ❒Average ❒Poor
Written ❒Excellent ❒Good ❒Average ❒Poor

Name of person who referred you to the scholarship program:_____
_____

Information About Your Program Plans

1. Academic major you intend to pursue:_____
2. Intended vocation:_____

Please include the following required information.

1. Complete academic records (copies of transcript and most recent diploma).
2. A personal essay, in English, describing your family background, your personal and professional goals, and plans upon graduation.
3. Reference letters from a teacher, clergy and employer, if applicable.
4. Documentation of annual family income (in U.S. dollars).
5. Recent photo.
6. Complete the Medical and Immunization section of application form.

Please read carefully

The three Universities are Christian institutions. Because of this we are interested in the personal as well as academic education of each of our students. Therefore, we offer opportunities for students to experience personal growth. Some of the opportunities are mandatory. These include: 1) attending chapel services, and 2) enrolling in Bible courses.

While all students are not required to be Christians in order to enroll at the Universities, all students are required to respect the environment, which is an important part of our Christian lifestyle. In particular, students are prohibited from smoking, drinking, using or possessing drugs and using profane language while on campus as well as any other regulations as outlined in the student handbook of the Universities.

I certify that to the best of my knowledge this information I have given is accurate and correct. **I understand that falsification of any information in this application is grounds for dismissal from the program.** Furthermore, I have read and do understand the above statement and, if admitted, will comply with all the rules and regulations set forth by the administrators of the Walton International Scholarship Program and the University granting me the scholarship. Finally, I will return to my home county when I complete my education at this University.

Signature:_____Date:_____

Medical and Immunization Record

The health history and immunization record is for use by the Student Health Services Office of John Brown University, Harding University, and University of the Ozarks. The contents of this record are confidential and will not be released without your consent.

Name_____Phone_____
Surname/Family Name First Middle

Current mailing address:_____
Number and Street

_____
City/Town State/Province Country

Birthdate_____ Social Security #: _____
Month/Day/Year

Family Physician:

Name_____ Telephone (_____)_____

Address_____
Number and Street

_____
City/Town State/Province Country

Emergency Notification:

Name_____ Relationship_____

Telephone: Day (_____)_____ Evening (_____)_____

Name_____ Relationship_____

Telephone: Day (_____)_____ Evening (_____)_____

Name_____ Relationship_____

Telephone: Day (_____)_____ Evening (_____)_____

Insurance Company_____ Policy #_____

Personal History:

Information on this form is for use by the University Health-Counseling staff. The contents are confidential and will not be released without your knowledge and consent.

Have you ever had:	No	Yes (currently)	Yes (previously)	Comments/Explanation
Asthma				
Allergies:				
Medication				
Food				
Plant				
Insect Bites				
Other				
Heart Murmur/Problem				
Kidney Stones/Disease				
Convulsions/Seizures				
Visual Problems				
Hearing Loss				
Arthritis				
Malaria				
Diabetes				
Hypoglycemia				
Thyroid Disease				
Anemia				
Anorexia/Bulimia				
Hepatitis				
Tuberculosis				
Rheumatic Fever				
Bleeding Disorder				
HIV Positive				
Surgery				
Headaches/Migraines				
Emotional Disturbance				
Epilepsy				
Other:_____				

Do you have a medical disability? ❒Yes ❒No If "yes," please specify:_____

_____

Are you under a physician's care now? ❒Yes ❒No If "yes," please specify:_____

_____

❒Allergy Shots ❒Laboratory Monitoring ❒Other:_____

List any prescription medications taken on a frequent or regular basis: (name, dosage, frequency)

_____

_____

Do you use syringes for self medication? ❒Yes ❒No

(If yes, you must sign a "Safe Needle Disposal" form at the Student Health Services Office upon arrival)

Is there anything the Health Services Office should know in order to give you better health care?

_____

_____

_____

Immunization Status

___ To be verified by Physician or Health Care Official. All students must have a documented history of immunizations verified by a physician. We will also accept immunization records from your doctor's office, the Health Department, or school records, but must include specific dates for each dose.

	Date Immunized (month/day/year)	**Date Immunized** (month/day/year)
Tetanus (within 10 years)		
Polio (last in series of 4)		
*Rubeola (measles)		
*Rubella (German or 30day measles)		
*MMR (Measles, Mumps, Rubeola)		

At this time, the American Medical Association recommends 2 MMR doses by the time of adulthood.

Arkansas state law requires that if you were born after January 1, 1957 you must have received both vaccines after your first birthday. If you are unable to do this prior to enrollment, you may receive it during registration at no charge.* ***Persons seeking a religious or medical exemption to the Immunization requirements of Arkansas institutions of higher education may obtain an application form from the Student Health Services Offices. Any exemption status must be completed before classes begin.*

Are there any existing health conditions that might need medical attention or monitoring such as special diets, medication levels, etc.? _____

_____

_____

_____

_____

Health Care Professional

(Signature of doctor, nurse, nurse practitioner, P.A., or D.O. is REQUIRED)

Consent for Treatment: Consent is hereby given for treatment in University of the Ozarks Student Health Services Office by duly licensed medical personnel or by a health care provider of choice in the community for routine health care, assessment, diagnosis, treatment, and if necessary, hospitalization. No guarantee has been made to me as to the results to be obtained by treatment given to me.

It is understood that the University will contact the next of kin as soon as possible in case of an emergency or serious illness.

Signed: _____ Date: _____

Parent or Guardian: _____ Date: _____

(if student is under 18 years of age)