

LOUISIANA STATE UNIVERSITY
HEALTH SCIENCES CENTER

APPLICATION FOR ADMISSION
SCHOOL OF DENTISTRY

PROGRAM IN DENTAL LABORATORY TECHNOLOGY

1100 Florida Ave., Box 228
New Orleans, LA 70119

Paste picture
here

Date _____ 20_____

Name in full _____
Last name First name Middle name

Mailing address _____
Number & street City Parish or County State Zip code

Permanent Home Address _____
Number & street City Parish or County State Zip Code

Telephone _____
Present Home Cell Phone

Date of birth _____ Place of birth _____
Month Day Year City State

Social Security number _____ E-Mail _____ Race _____

For the previous tax year, which person claimed you as a deduction? _____ Father _____ Mother _____ Guardian _____ Spouse _____ Self

American Citizen? Yes _____ No _____ If not, indicate citizenship _____ Visa status: Student _____ Resident _____ Other _____

Alien Registration # _____ (Enclose photocopy of both sides of card)

If you have not been living at your present address for a period of two years, list your home address for the past two years. Show street, number, city, and state.

_____ Since: Month _____ Year _____

_____ Since: Month _____ Year _____

Provide the information requested below concerning your parents or guardians (if they are providing financial support for your education).

Name of father/guardian _____ Living? _____

Home address _____ Since: Month _____ Year _____

Previous Address _____ Since: Month _____ Year _____

Occupation _____ Firm or business name _____

Name of mother _____ Living? _____

Home address _____ Since: Month _____ Year _____

Previous Address _____ Since: Month _____ Year _____

Occupation _____ Firm or business name _____

Give information concerning high school or other secondary schools attended.

Name of School	City and State	Date of Entrance	Date of Leaving	Diploma Received

Give information concerning colleges or universities attended.

Name of School	City and State	Date of Entrance	Date of Leaving	Diploma Received

Have you ever been dropped or suspended for scholastic or disciplinary reasons from any high school or college? _____

(Explain) _____

If time since high school graduation to the present is not completely covered (except summers) by your attendance in college, indicate employment, time spent on active duty in the Armed Forces, or other activity. Begin with most recent date.

Name of employer or activity	City & State	Date (month & year)	
_____		From _____	To _____
_____		From _____	To _____
_____		From _____	To _____
_____		From _____	To _____

HAVE YOU PREVIOUSLY APPLIED TO THIS INSTITUTION? YES _____ NO _____

YOUR APPLICATION IS FOR THE FALL SEMESTER OF 20_____

Have you ever been convicted, pleaded guilty, or are you presently charged by indictment or information with a crime (felony)? _____ Have you ever been committed to a juvenile correctional, or training institution? _____ (If answer is yes, give details on a separate sheet.)

State law requires that all males register for the federal draft, under the federal Military Selective Service Act, prior to your enrollment in any institution of the LSU System, which includes all the schools of the LSU Health Sciences Center. Please sign your name on the line below indicating that you are in compliance with this state law. I, _____, have registered with the selective service system in accordance with the Military Selective Service Act. *(Print your name)*

(Signature)

(Date)

If you are not required to register with the selective service system, please indicate below the reason why.

*** You must also furnish this office with a copy of your Selective Service Registration Card as proof of your registration.**

In the space below please write in your *own handwriting* an account of your reasons for selecting dental laboratory technology as a career.

YOUR APPLICATION IS INCOMPLETE AND CANNOT BE PRESENTED TO THE COMMITTEE ON ADMISSIONS UNTIL ALL CREDENTIALS ARE RECEIVED. THIS INCLUDES THE APPLICATION, APPLICATION FEE, PICTURE, AND LEGIBLE PHOTOCOPY OF DRIVERS'S LICENSE, OFFICIAL TRANSCRIPTS, AND CONFIDENTIAL RATING FORM.

I hereby certify that all statements made in connection with application are correct.

CONSENT: I hereby give my permission to Louisiana State University School of Dentistry to release information regarding my admission credentials to those agencies the School authorizes as appropriate.

Date _____ Signature of applicant _____