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# VERIFICATION OF LOUISIANA RESIDENCY

Date \_\_\_\_\_ 20\_\_\_\_\_

I hereby apply for the Dental Hygiene Program of the Louisiana State University School of Dentistry,

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 \_\_\_\_\_ *home cell phone* Maiden name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_ *City, State* Spouse \_\_\_\_\_

Social Security number \_\_\_\_\_ Email \_\_\_\_\_ Race \_\_\_\_\_

Vehicle registration number \_\_\_\_\_ State \_\_\_\_\_ Date issued \_\_\_\_\_

Registered to Vote in LA? \_\_\_\_\_ Parish \_\_\_\_\_ Ward \_\_\_\_\_ Precinct \_\_\_\_\_ Date registered \_\_\_\_\_

US citizen \_\_\_\_\_ if not, type of Visa \_\_\_\_\_ Date issued \_\_\_\_\_ Visa number \_\_\_\_\_ (attach copy –front & back)

Were you claimed as a dependent on any person's Federal or State Income Tax Return either or both of the past two years? \_\_\_\_\_

Tax year \_\_\_\_\_ Person claiming you as a dependent \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tax year \_\_\_\_\_ Person claiming you as a dependent \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Did you file a Louisiana income tax return in the last 12 months? \_\_\_\_\_ List years you have filed in LA returns \_\_\_\_\_

If you did not file a Louisiana return in the past 12 months, please state reason(s):

\_\_\_\_\_

Have you filed an income tax return in another state? \_\_\_\_\_ List years for which you have filed returns in another state \_\_\_\_\_

Do you own property in Louisiana? \_\_\_\_\_ If yes, list the location \_\_\_\_\_

Please be advised that the LSU School of Dentistry Admissions Committee may require documents supporting your residency. (i.e. voter registration card, driver's license, vehicle registration or income tax return)

Have you ever been convicted, pleaded guilty, or are you presently charged by indictment or a bill of information with a crime (felony) that might be punishable by imprisonment? (If answer is yes, give details.)

\_\_\_\_\_

Have you ever been committed to a juvenile, correctional or training institution? (If answer is yes, give details.)

\_\_\_\_\_

List all of your addresses for the past five years. (Most recent first)

Street address	City	State	Date

List all schools attended from high school to present school. (Most recent first)

School	City	State	Dates

List all the firms or persons by whom you have been employed during the past five years. (Most recent first)

Employer	City	State	Dates

Explain any circumstances by which you claim to be a resident of Louisiana other than the above items, (attach additional information, if needed).

\_\_\_\_\_

\_\_\_\_\_

Please rank in order of preference:

- 1) \_\_\_\_\_ The LSU Program in Dental Hygiene at the New Orleans Campus ONLY.
- 2) \_\_\_\_\_ The LSU Program in Dental Hygiene at the Alexandria Campus ONLY.
- 3) \_\_\_\_\_ Either Location

Have you previously applied to this institution's dental hygiene program?      Yes      No      Date Applied? \_\_\_\_\_

Application fee paid on-line thru portal    Yes    No    Date paid: \_\_\_\_\_

I hereby certify that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Louisiana State University System to verify all facts relevant to my claim for residence.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

Give information concerning high school or other secondary schools attended.

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

Give information concerning colleges or universities attended.

Name of School	City, 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? (If yes, please explain circumstances.) \_\_\_\_\_  
 \_\_\_\_\_

Please indicate any of the following, beginning with most recent date:

1. Employment history in a dental office      Yes      No      Employer \_\_\_\_\_
2. Any time spent volunteering or shadowing in a dental office      Yes      No      Approximate hours \_\_\_\_\_
3. Any time spent on active duty in the Armed Forces.      Yes      No

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 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.