



**TENNESSEE COLLEGE  
OF APPLIED TECHNOLOGY**  
MCMINNVILLE

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**ALLIED HEALTH  
APPLICATION FOR ENROLLMENT**

**PLEASE PRINT ALL INFORMATION**

**NOTICE:** Your application for enrollment is not complete until you have provided an official high school/GED transcript and proof of MMR and Varicella immunizations. Applicants must also complete prerequisite classes in Anatomy & Physiology and Dosage Calculation Math.

Please indicate the program you would like to take:  Hybrid Practical Nursing  
 Practical Nursing

LAST NAME:	FIRST NAME:	MIDDLE:	MAIDEN:
SOCIAL SECURITY NUMBER: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
STREET ADDRESS/ROUTE/P. O. BOX:			
CITY:	STATE:	ZIP:	COUNTY:

EMAIL ADDRESS:

HOME PHONE: ( ) ( )	CELL PHONE: ( ) ( )	EMERGENCY PHONE: ( ) ( )	WORK PHONE: ( ) ( )
DATE OF BIRTH: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Date Year		PLACE OF BIRTH: City: State:	

**INDICATE THE HIGHEST LEVEL OF YOUR EDUCATION (X)**  
 High School Diploma     GED     Some College or Other Training     College Graduate

HIGH SCHOOL ATTENDED:	CITY:	STATE:	LAST DATE ATTENDED OR GRADUATION DATE

List any high school math, science & health courses taken:

COLLEGE OR VOCATIONAL SCHOOL:	CITY:	STATE:	LAST DATE ATTENDED OR GRADUATION DATE

List courses taken:

OTHER TRAINING:

## EMPLOYMENT HISTORY

List all present and past employment, beginning with your most recent. Attach additional sheets, if necessary.

<b>Name of Employer:</b>	
<b>Address:</b>	
<b>Supervisor:</b>	<b>Type of Business:</b>
<b>Dates of Employment:</b> From	To
<b>Title/Position:</b>	
<b>Starting Salary:</b>	<b>Ending Salary:</b>
<b>Hours worked per week:</b>	<b>Number of employees supervised:</b>
<b>Reason for Leaving:</b>	
<b>Responsibilities and Duties:</b>	

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<b>Responsibilities and Duties:</b>	

Have you had any health occupations experience?  Yes  No

If yes, explain:

Where:

Type of work:

Dates:

Have you ever been accused of patient abuse?  Yes  No  
If yes, on back of this application describe situation, give dates, location, etc.

Does your name appear on the "Abuse Registry" in Tennessee or any other state?  Yes  No

Have you ever been convicted of anything other than a minor traffic violation?  Yes  No

Are you currently incarcerated?  Yes  No

**REFERENCES**

Persons with no work history may provide character references (relatives are not acceptable as references)

NAME	ADDRESS	PHONE

Are you a U. S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, are you a permanent resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Origin: _____ Alien Registration Number: _____
Are you eligible to register for the Federal Draft? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you registered? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> I have completed a current FAFSA <input type="checkbox"/> I will complete a current FAFSA <input type="checkbox"/> I have made other financial plans	
<b>When will you be available to begin training?</b> (The date you list does not guarantee your entrance on that date.)	

**Briefly explain why you want to be in our Allied Health program and why you want to become a health care professional**

The facts set forth in this application are true and complete. I understand that falsification of information could result in disqualification or termination from the program.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date