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MICROVASCULAR PROFESSIONAL (MVP) PROGRAM APPLICATION

For internal use ONLY: Academic Year _____ Full-Time Student-At-Large

APPLICANT INFORMATION

NAME:			
SALUTATION:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
DATE OF BIRTH:			GENDER: <input type="checkbox"/> M <input type="checkbox"/> F
Ethnic Background: <i>(please check all that apply)</i>			
<input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			
Citizenship:			
<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Visa Type of Visa _____ <i>(if applicable)</i>			
Email Address:			
Home Phone:			Cell Phone:
Permanent Address:			
Mailing Address: (if different from permanent)			
<input type="checkbox"/> Same as permanent address			
Emergency Contact:	Contact 1 Name:	Contact 1 Phone Number:	
	Contact 2 Name:	Contact 2 Phone Number:	

Military Service:	
<input type="checkbox"/> Veteran <input type="checkbox"/> Active Duty <input type="checkbox"/> Branch of Service _____ <i>(if applicable)</i>	
Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, please explain each charge and conviction fully below (may use a separate sheet if needed):</i>	



Applicant Name: _____

ADDITIONAL LICENSING

Do you have other professional licenses? Yes No Have you ever been disciplined on any professional licenses? Yes No

Other License Name	License Number	State Issued	License Disciplined
			<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain
			<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain

You may provide additional licensing information on the back of this page if more space is needed for explanations.

APPLICATION CHECKLIST

Please note that your application cannot be processed without the application fee and all accompanying documents. When submitting your application please ensure that:

- The entire application form is completed, signed and dated.
 - A copy of a government issued photo ID is included.
 - All official transcripts are sent to NCNM from institutions listed on application.
 - Include 2 letters of recommendation: 1 Professional source and 1 Personal source
 - Enclose the \$50 non-refundable application fee.
- Please make cashier check or money order payable to The National College of Naprapathic Medicine or NCNM.*

A Smoke-Free Policy has been established for the College Premises

The National College of Naprapathic Medicine does not discriminate on the basis of race, religion, creed, sex, age, marital status, disability, national origin or sexual orientation in its educational programs, activities or employment practices.

ACKNOWLEDGEMENT

"I hereby acknowledge that I have been informed of and understand that Naprapathic treatment primarily involves using the hands in physical, skin to skin contact with the patient for manual manipulation of the connective tissues (muscles, ligaments, etc.) of the human body. I further understand that the practice of Naprapathic Medicine can require the application of significant manual pressure on the body of the patient, and that Naprapathic practice can also require the careful observation of the movements of a patient. I hereby consent to such physical contact to my body by others, and I hereby consent to making such physical contact with others to the extent such procedures are a scheduled part of the Naprapathic and affiliated studies of NCNM."

DECLARATION

I hereby apply for admission to the National College of Naprapathic Medicine (NCNM). I understand the application fee covers the cost of processing the application and is not refundable. I hereby affirm and declare that all statements contained in this application for admission are true, correct and complete and that I have not misrepresented or withheld any fact that would, if fully and accurately disclosed affect my application unfavorably. I understand that false statements, misrepresentations, and / or omissions on this application may be considered sufficient cause for rejection of this application, or, if successfully admitted, suspension or expulsion from the National College of Naprapathic Medicine (NCNM) upon discovery of any such false statement.

Applicant Signature

Date