

Robert D. and Carol Gunn College of

Health Sciences and Human Services

Department of Health Services Administration

3410 Taft Blvd, Martin Hall 107

Wichita Falls, TX 76308-2099

Phone (940) 397-4752

**Application for Admission to the Graduate Program in Health Services Administration\***

Please, return this form to: MSU Graduate School, 3410 Taft Blvd, Wichita Falls, TX 76308-2099

email: graduateschool@mwsu.edu | fax: 940.397.4926

1. General Information
2. Application Classification: [ ]  New Student [ ]  Re-admission [ ]  Auditing
3. Desired entry date: Semester/Year     Date of application: mm/dd/yy
4. Please note the concentration area you wish to complete:

[ ]  Health Information Management

[ ]  Medical Practice Management

[ ]  Public and Community Sector Health Care Management

[ ]  Rural and Urban Hospital Management

1. Personal Information
2. Student ID: **M**
3. Name: Last name     First Name     M.I.    Madien (if applicable)
4. Home Address: Street Address

 City, State, Zip, (Country)

1. Home Phone:       Work Phone:       Cell Phone:
2. Email:
3. Permanent Address (if different from current address):

 Street Address

 City, State, Zip, (Country)

1. Academic Information
2. Please indicate your scores for one of the following if available:

GRE Exam Date: mm/dd/yy     Scores: verbal quantitative writing total

GMAT Exam Date: mm/dd/yy     Scores: verbal quantitative writing total

If you have not taken an exam, please, indicate the date which you expect to take it. Please, note that the GRE is preferred but GMAT scores are accepted.

Test: [ ]  GRE [ ]  GMAT Scheduled test date: mm/dd/yy

1. Current Academic/Professional Degrees (check all that apply):

[ ]  BA/BS [ ]  MA/MS [ ]  MD/JD [ ]  PhD/EdD

1. List ALL colleges and universities you have attended in chronological order (including those from which you did not graduate)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of School | Dates of Attendance | Degree | Major |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |

1. List ALL Employers or Military Service in chronological order. Use additional sheet of paper, if required.

|  |  |  |  |
| --- | --- | --- | --- |
| Employer | Employment Dates | Position | Major Duty |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |
|       | mm/yyyy to mm/yyyy     |       |       |

1. List Professional and Community Affiliations, Offices Held, Committees, Positions



1. Please, describe the top five professional goals you hope to achieve by pursuing your health administration degree.

|  |
| --- |
| 1.
 |
| 1.
 |
| 1.
 |
| 1.
 |
| 1.
 |

1. List the names and addresses of three individuals who you will ask to provide references for the HSA program. It is recommendation that at least one reference be from an educator familiar with your academic performance.
2. Reference Name     Street Address, City, State, Zip (Country)
3. Reference Name     Street Address, City, State, Zip (Country)
4. Reference Name     Street Address, City, State, Zip (Country)

I certify that the information in this application is complete and correct to the best of my knowledge and belief, and understand that submission of any false information or incomplete information is grounds for rejection of my application, withdrawal of any acceptance, or dismissal after enrollment.

**Signature Date**