

WALTON INTERNATIONAL SCHOLARSHIP PROGRAM



APPLICATION FORM

Harding University

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Walton International Scholarship Program Application Form

Part A: Personal Data

1. Full Name _____
Surname/Family Name First Middle

2. Current mailing address: _____
Number and Street

_____ City/Town State/Province Country

_____ Telephone: (____) _____
Postal Code Country Code City Code

Email address _____

3. Citizenship: _____ Date of Birth: _____

City of Birth: _____ Country of Birth: _____

Passport Number: _____ Issued at: _____

Sex: Male Female Marital Status: Single Married Divorced

4. Religious Affiliation/Preference: _____

5. Have you ever visited or lived in the U.S.? If "yes," how long? Please explain: _____

6. Have you ever had or do you currently have a U.S. Passport or Visa to enter the U.S.?
 Yes No If "yes," please explain: _____

7. Health: Excellent Good Fair Poor *Please complete medical section of application form.*

Part B: Parental Data

8. Name of: Parent Legal Guardian Other Relative

_____	_____
Surname/Family Name	First
_____	_____
Number and Street	City/Town
_____	_____
State/Province	Country
_____	_____
Postal Code	Telephone Number
_____	_____
E-mail address	

Father's Occupation _____
Mother's Occupation _____
Estimated Total Family Income _____
Religious Affiliation _____

9. Names and addresses of any relatives or friends living in the United States:

Name	Address	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Part C: Academic Data

10. List in chronological order, from high school/secondary to the present, the schools and Universities you have attended.

School	Location	Dates	Degree/Diploma
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you taken the required TOEFL (Test of English as a Foreign Language)? Yes No
If "yes," what was your score: _____

Indicate your level of English proficiency: Spoken Excellent Good Average Poor
Written Excellent Good Average Poor

Name of person who referred you to the scholarship program: _____

Information About Your Program Plans

1. Academic major you intend to pursue: _____
2. Intended vocation: _____

Please include the following required information.

1. Complete academic records (copies of transcript and most recent diploma).
2. A personal essay, in English, describing your family background, your personal and professional goals, and plans upon graduation.
3. Reference letters from a teacher, clergy and employer, if applicable.
4. Documentation of annual family income (in U.S. dollars).
5. Recent photo.
6. Complete the Medical and Immunization section of application form.

Please read carefully

The three Universities are Christian institutions. Because of this we are interested in the personal as well as academic education of each of our students. Therefore, we offer opportunities for students to experience personal growth. Some of the opportunities are mandatory. These include: 1) attending chapel services, and 2) enrolling in Bible courses.

While all students are not required to be Christians in order to enroll at the Universities, all students are required to respect the environment, which is an important part of our Christian lifestyle. In particular, students are prohibited from smoking, drinking, using or possessing drugs and using profane language while on campus as well as any other regulations as outlined in the student handbook of the Universities.

I certify that to the best of my knowledge this information I have given is accurate and correct. **I understand that falsification of any information in this application is grounds for dismissal from the program.** Furthermore, I have read and do understand the above statement and, if admitted, will comply with all the rules and regulations set forth by the administrators of the Walton International Scholarship Program and the University granting me the scholarship. Finally, I will return to my home county when I complete my education at this University.

Signature: _____ Date: _____

Medical and Immunization Record

The health history and immunization record is for use by the Student Health Services Office of John Brown University, Harding University, and University of the Ozarks. The contents of this record are confidential and will not be released without your consent.

Name _____ Phone _____
Surname/Family Name First Middle

Current mailing address: _____
Number and Street

City/Town State/Province Country

Birthdate _____ Social Security #: _____
Month/Day/Year

Family Physician:

Name _____ Telephone _____
(_____) _____

Address _____
Number and Street

City/Town State/Province Country

Emergency Notification:

Name _____ Relationship _____

Telephone: Day (_____) _____ Evening (_____) _____

Name _____ Relationship _____

Telephone: Day (_____) _____ Evening (_____) _____

Name _____ Relationship _____

Telephone: Day (_____) _____ Evening (_____) _____

Insurance Company _____ Policy # _____

Personal History:

Information on this form is for use by the University Health-Counseling staff. The contents are confidential and will not be released without your knowledge and consent.

Have you ever had:	No	Yes (currently)	Yes (previously)	Comments/Explanation
Asthma	_____	_____	_____	_____
Allergies:	_____	_____	_____	_____
Medication	_____	_____	_____	_____
Food	_____	_____	_____	_____
Plant	_____	_____	_____	_____
Insect Bites	_____	_____	_____	_____
Other	_____	_____	_____	_____
Heart Murmur/Problem	_____	_____	_____	_____
Kidney Stones/Disease	_____	_____	_____	_____
Convulsions/Seizures	_____	_____	_____	_____
Visual Problems	_____	_____	_____	_____
Hearing Loss	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Malaria	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Hypoglycemia	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Anemia	_____	_____	_____	_____
Anorexia/Bulimia	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Rheumatic Fever	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____
HIV Positive	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Headaches/Migraines	_____	_____	_____	_____
Emotional Disturbance	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Do you have a medical disability? Yes No If "yes," please specify: _____

Are you under a physician's care now? Yes No If "yes," please specify: _____

Allergy Shots Laboratory Monitoring Other: _____

List any prescription medications taken on a frequent or regular basis: (name, dosage, frequency)

Do you use syringes for self medication? Yes No
 (If yes, you must sign a "Safe Needle Disposal" form at the Student Health Services Office upon arrival)

Is there anything the Health Services Office should know in order to give you better health care?

Immunization Status

___ To be verified by Physician or Health Care Official. All students must have a documented history of immunizations verified by a physician. We will also accept immunization records from your doctor's office, the Health Department, or school records, but must include specific dates for each dose.

	Date Immunized (month/day/year)	Date Immunized (month/day/year)
Tetanus (within 10 years)		
Polio (last in series of 4)		
*Rubeola (measles)		
*Rubella (German or 30day measles)		
*MMR (Measles, Mumps, Rubeola)		

At this time, the American Medical Association recommends 2 MMR doses by the time of adulthood.

Arkansas state law requires that if you were born after January 1, 1957 you must have received both vaccines after your first birthday. If you are unable to do this prior to enrollment, you may receive it during registration at no charge. **Persons seeking a religious or medical exemption to the Immunization requirements of Arkansas institutions of higher education may obtain an application form from the Student Health Services Offices. Any exemption status must be completed before classes begin.*

Are there any existing health conditions that might need medical attention or monitoring such as special diets, medication levels, etc.? _____

Health Care Professional
(Signature of doctor, nurse, nurse practitioner, P.A., or D.O. is REQUIRED)

Consent for Treatment: Consent is hereby given for treatment in University of the Ozarks Student Health Services Office by duly licensed medical personnel or by a health care provider of choice in the community for routine health care, assessment, diagnosis, treatment, and if necessary, hospitalization. No guarantee has been made to me as to the results to be obtained by treatment given to me.

It is understood that the University will contact the next of kin as soon as possible in case of an emergency or serious illness.

Signed: _____ Date: _____

Parent or Guardian: _____ Date: _____
(if student is under 18 years of age)