

# WALTON INTERNATIONAL SCHOLARSHIP PROGRAM



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## APPLICATION FORM

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### **Harding University**

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### **University of the Ozarks**

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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

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.

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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)

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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?

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## 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.? \_\_\_\_\_

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\_\_\_\_\_  
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)