UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

APPLICATION FOR ADMISSION
MANUAL THERAPY FELLOWSHIP

Admission Application Procedures

- ***Application for Admission***
  Applications can be submitted at any time and must be accompanied by a $50.00 processing fee (check or money order in US currency made payable to University of St. Augustine). Read all questions and answer completely. Do not leave any blanks. Mark the appropriate space N/A if the question does not apply. Supporting documentation that accompanies the application should be properly labeled. Please call the Student Services office at (800) 241-1027 or email admissions@usa.edu with any questions you may have about the application process.

- ***Transcripts, References and Other Required Supporting Documentation***
  - You must provide official transcripts from each institution you attended for graduate or undergraduate education
  - You must provide two (2) references. The persons used as references should have worked with you in the clinical environment.
  - You must also provide:
    - Copy of professional state license
    - Current resume which lists continuing education involvement and professional publications
    - Current photograph
    - Essay to respond to the following questions:
      - What do you bring to this Fellowship?
      - Why are you a good match for this Fellowship program?
    - If applying for an on-campus Fellowship an additional Essay that describes your interest in teaching, present and future

- ***Minimum Admission Requirements***
  - Licensure (or eligible for licensure) in the state where the fellowship mentoring/practice will occur
  - A minimum of two (2) years of clinical practice in orthopaedics or completion of an APTA credentialed Orthopaedic Residency program
  - Completion of E1 and S1 seminars at the University of St. Augustine
  - Evidence of interest in manual therapy
  - Professional behaviors and enthusiasm in orthopaedic manual physical therapy
  - Demonstrated motivation and commitment to the profession
  - Excellent verbal and written communication skills
  - Clinical reasoning skills and the application of examination and treatment procedures

Completed applications and supporting documentation should be submitted to:

University of St. Augustine for Health Sciences
Student Services Office
1 University Boulevard
St. Augustine, FL 32086-5799
admissions@usa.edu

GENERAL PROCESSING INFORMATION:

Program location (mark all that apply): _____St. Augustine Campus ___San Diego Campus ___Off-Campus

If off-campus do you have a preferred location? _____

Are you interested in completing the Fellowship on a full-time or part-time basis? _____Full-time ___Part-time.

List the month and year you would like to start the program: _____

Are you enrolled in a USA degree program?_ If yes, list program, year and term:_____

Are you a graduate of a USA degree program?_____ If yes, list program and year:_____

Do you have a mentor that is a FAAOMPT? _____Yes ____No

If yes, list name and location _____

BIOGRAPHIC INFORMATION:

1. Name _____
Last *First* *Middle*

If transcripts, test scores, etc. might arrive under any name(s) other than the above, enter here:_____

2. Preferred First Name:_____ 3. Email Address: _____

4. Cell Phone: (_____)_____-_____ 5. Work Phone (_____)_____-_____

6. Permanent Address: _____
Street, Post Office Box, Rural Route

_____
City *State* *Zip*

7. Home Phone: (_____)_____-_____ 8. Fax number: (_____)_____-_____

9. Social Security Number_____-_____-_____ 10. Date of Birth _____/_____/_____

11. Gender: ____Male ____Female 12. Marital Status: _____Single _____Married

13. Citizenship Status: ____U.S. Citizen ___Resident Alien (*submit copy of card)*
____Naturalized US Citizen ___Other: _____

14. What is your ethnicity (check one)? ____ Hispanic or Latino ___ Not Hispanic or Latino

15. Select one or more of the following races:

___ American Indian or Alaska Native, not Hispanic or Latino
___ Black or African American, not Hispanic or Latino
___ White, not Hispanic or Latino
___ Asian, not Hispanic or Latino
___ Native Hawaiian or other Pacific Islander, not Hispanic or Latino

16. Emergency Contact:
Name_____ Relationship _____

Address: _____
Street, Post Office Box, Rural Route

_____
City *State* *Zip*

Phone: (_____)_____-_____

College/University Record:

List in chronological order (most recently attended first) every college and university which you have attended or will be attending prior to entering a program at the University of St. Augustine (use additional paper if needed).

College/ University _____ City/State_____ Dates of Attendance (Month/Year): _____/_____ to _____/_____ Degree Earned/Expected_____ Date Degree Awarded_____ Major_____

College/ University _____ City/State_____ Dates of Attendance (Month/Year): _____/_____ to _____/_____ Degree Earned/Expected_____ Date Degree Awarded_____ Major_____

College/ University _____City/State_____
Dates of Attendance (Month/Year): _____/_____to _____/_____Degree Earned/Expected_____
Date Degree Awarded_____Major_____

College/ University _____City/State_____
Dates of Attendance (Month/Year): _____/_____to _____/_____Degree Earned/Expected_____
Date Degree Awarded_____Major_____

Clinical Practice Record:

List the last three clinical practice settings which you have worked (most recent first).

Name of facility _____Dates of employment (month/year) __/__ to __/_____
Location _____Type of clinical practice _____

Name of facility _____Dates of employment (month/year) __/__ to __/_____
Location _____Type of clinical practice _____

Name of facility _____Dates of employment (month/year) __/__ to __/_____
Location _____Type of clinical practice _____

Certifications:

Have you achieved Manual Therapy Certification from the University of St. Augustine for Health Sciences?_____
If yes, list year:_____ If no, when do you expect to apply to take certification?_____

Have you achieved any other Certifications? _____ Please list type and year achieved._____
_____
_____

Have you achieved ABPTS clinical specialty from APTA? _____ If yes, what specialty designation and year?
_____

Professional Information:

Check the USA seminars attended and year:

*E1 _____ *S1 _____
E2 _____ S3 _____
MF1_____ S4 _____
S2 _____ Thrust_____

*Completion of E1 and S1 is an admissions requirement.

Please check or list the professional organizations to which you belong. List dates of participation.

APTA _____ Orthopaedic Section _____
Other sections APTA House of Delegates _____
State organizations _____ AAOMPT _____
Other _____ Other _____

Are you interested in pursuing a higher degree through USA or another university? _____Yes ____No ____Undecided

References:

List the names of individuals who are submitting the required reference forms for you. Please refer to the supplemental documentation.

1) _____
Name Title

_____
Address Telephone number

2) _____
Name Title

_____
Address Telephone number

Other:

Have you ever been convicted of a felony? _____ If yes, please explain on a separate sheet of paper.

Please indicate your primary source of information about the University of St. Augustine:

_____University of St. Augustine website
_____Continuing education seminar*
_____USA information session
____Professional website of publication
____USA student or alumnus
____Professional meeting*
____Colleague
____USA Representative
____Social Media
____Other*

*Please describe_____
_____
_____

Directory Information relating to a student is considered to be public information unless the student requests that it be kept confidential. A form to restrict disclosure of directory information is available at the Student Services Office. Directory information consists of: student's name, address, telephone number, date and place of birth, class standing, major field of study, dates of attendance, degrees and awards received, most recent previous educational agency or institution attended, current class schedule, and other similar information.

Important. You must read and sign the following section in order to complete your application.

I further agree to the release of any transcript, test score, and reference to this institution necessary for admission processing.

I hereby certify that I have not made any willful misrepresentations pertinent to this application and that the information given in this application is complete and accurate. I understand that to make false statements within this application may result in disciplinary action, denial of admission and invalidation of credits or degrees earned. If admitted, I hereby agree to abide by the policies and regulations of the University of St. Augustine for Health Sciences. Should any of the information I have given change prior to my matriculation at the University, I shall immediately notify the Student Services Office.

_____ _____
Signature of Applicant (in ink) Date

The University of St. Augustine for Health Sciences admits students of any race, color, religion, gender, marital status, age and national or ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, religion, gender, marital status, age and national or ethnic origin in administration of its educational policies, scholarship and loan programs, or any other school administered programs.

UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

REQUIRED SUPPORTING DOCUMENTATION

The following documentation must be submitted with your application:

Orthopaedic Residency Program:

- Official transcripts from each institution you attended for graduate or undergraduate education
- Two (2) references. The persons used as references should have worked with you in the clinical environment.
- Copy of professional state license
- Current resume which lists continuing education involvement and professional publications
- Current photograph
- **Essay** to respond to the following questions:
    - *What do you bring to this residency program?*
    - *Why are you a good match for this residency program?*

Manual Therapy Fellowship Program:

- You must provide official transcripts from each institution you attended for graduate or undergraduate education
- Two (2) references. The persons used as references should have worked with you in the clinical environment.
- Copy of professional state license
- Current resume which lists continuing education involvement and professional publications
- Current photograph
- **Essay** to respond to the following questions:
    - *What do you bring to this Fellowship program?*
    - *Why are you a good match for this Fellowship program?*
- If applying for an on- campus Fellowship an additional **Essay** that describes your interest in teaching, present and future
- Candidates must document a minimum of two (2) years of clinical practice in orthopaedics or completion of an APTA credentialed Orthopaedic Residency program.

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Reference Form for Applicants to the following programs:

Orthopaedic Residency
Manual Therapy Fellowship

Name of Applicant: _____ Date:_____

This applicant has applied for admission to an advanced or transitional degree program at the University of St. Augustine for Health Sciences. This is a distance education program. Your name has been given as a reference, and you are asked to evaluate the applicant.

NOTICE ON CONFIDENTIALITY: Applicants for admission do not have access to their application records. Under the provisions of the Family Educational Rights and Privacy Act of 1974, only registered (admitted) students and alumni have access to their educational records. This reference will be used solely for the purpose of determining whether or not the applicant is admitted to the University. This reference will be removed from the accepted student's file and destroyed when the student has matriculated.

Please place an "X" in the rating column appropriate to your assessment of the applicant.

	Excellent/ Exceptional	Above Average	Average	Below Average	Unable to Judge	Comments
1. Effective Use of Time and Resources: Obtains maximum benefit from a minimum investment of time and resources						
2. Responsibility: Fulfills commitments; accountable for actions and outcomes						
3. Commitment to Learning: Ability to self-assess, self-correct and self-direct; identifies needs and sources of learning; seeks new knowledge and understanding						
4. Problem Solving: Recognizes and defines problems; develops and implements solutions, evaluates outcomes						
5. Maturity: Self-control, realistic self-appraisal, ability to cope with life situations and stress						
6. Perseverance: Steadfastness in purpose, disciplined work habits, stamina and endurance						
7. Critical Thinking: Questions and argues logically; distinguishes the relevant from the irrelevant						
8. Interpersonal Relations: Sensitive to and effectively responds to the feelings and needs of others						
9. Communication Skills: Command of oral and written language, clarity of expression						
10. Intellectual Ability: Facility in understanding new ideas, insight						
11. Professionalism: Exhibits appropriate professional conduct; solid commitment based on realistic view of the profession						

How long have you known the applicant?_____

In what capacity?_____

Please use this space for any additional observations about the applicant.

Strengths:

Area(s), if any, where improvement might be needed:

Please check the statement below that best summarizes your recommendation for this applicant's application for admission to the University of St. Augustine:

o Recommend Highly

o Recommend

o Recommend with stipulation or reservation (please explain)_____

o Do Not Recommend

Signature_____ Date_____

Print Name and Title_____

Professional license number and state, if applicable _____

Telephone Number (_____) _____-_____ Email: _____

IMPORTANT MAILING INSTRUCTIONS: PLEASE PLACE THE COMPLETED REFERENCE FORM IN AN ENVELOPE, SEAL IT AND SIGN ACROSS THE SEAL. The sealed, signed envelope may be given to the applicant or sent directly to the following address:

University of St. Augustine for Health Sciences
Student Services Office
1 University Blvd.
St. Augustine, FL 32086

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o Recommend Highly

o Recommend

o Recommend with stipulation or reservation (please explain)_____

o Do Not Recommend

Signature_____ Date_____

Print Name and Title_____

Professional license number and state, if applicable _____

Telephone Number (_____) _____-_____ Email: _____