901 West Park Ave St 201
Ocean, NJ 07712
(732) 695 – 1190
admin@mcinj.edu

Application for Enrollment

All prospective students are required to complete this form as part of the admissions process. Completion of this application does not guarantee acceptance into the selected program. MCI does not discriminate on the basis of gender, handicap, race, color, creed, age, marital status, national or ethnic origin.

Program of Interest: ☐ DMS ☐CVS ☐ ST ☐ SPT ☐ MA

Program Schedule*: ☐ Day (Monday – Thursday 8:30AM – 2:00 PM) ☐ Evening (Monday – Thursday 4:30PM – 9:30PM)

Clinical placement is at any affiliated site in New Jersey. The schedule may include weekends, evenings and holidays.

Last Name: ______________________________**First Name** ________________**M.I** ___ **DOB:** ___________ **SS#** _____-____-_____

Home Address: ____ **Apt #**_________________

City: ____ **State:** _____________________ **Zip:** _______________

Email: ____ **Phone:** ____

The data below is required by the U.S. Department of Education

Race and Ethnicity:

1. Are you Hispanic or Latino? ☐ Yes ☐ No
2. Select one or more of the following races:
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White

Citizenship: ☐US Citizen ☐ Eligible Noncitizen ☐ Noncitizen

Gender: ☐ Male ☐ Female ☐ X

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced

Are you currently employed? ☐Yes ☐No

If yes, are you working: ☐ Full-time ☐ Part-time

High-School/GED: ____**Graduated:** ☐ Yes ☐ No

Trade School: ____ **Credits:** _______________**Graduated:** ☐ Yes ☐ No

College: ____ **Credits:** _______________**Graduated:** ☐ Yes ☐ No

Foreign Degree: ____ **Credits:** _______________**Graduated:** ☐ Yes ☐ No

First time at a Postsecondary School? ☐Yes ☐No

Healthcare Work Experience? ☐Yes ☐No ____

Current Employer: ____

Program Funding: ☐ Financial Aid (Pell Grants/Student Loans) ☐ Unemployment Grant ☐GI Bill ☐ Self-Pay

Do you have any known allergies? ☐Yes ☐No If Yes: ____

Emergency Contact:

Name: ____ **Phone:** _____________________ **Relationship**: _________________

By signing below, I hereby certify that the information provided is true and accurate to the best of my knowledge. I understand that the submission of any false information may result in a dismissal from the school. In addition, I understand that upon my enrollment, I have to abide by the policies and regulations of MCI Institute of NJ.

Name **Signature** **Date**

Admissions Office Use Only

Program: ☐ DMS ☐CVS ☐ ST ☐ SPT ☐ MA **Approved** ☐ **Provisional:** ☐

Notes: ____