

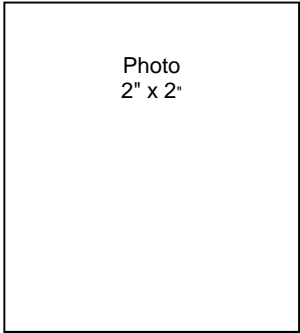


ST. LUKE'S COLLEGE OF MEDICINE

William H. Quasha Memorial

APPLICATION FOR ADMISSION

SCHOOL YEAR _____



NAME
(Please Print) LAST FIRST MIDDLE

Mailing Address _____ Tel. No. _____

Permanent Address _____ Tel. No. _____

_____ Zip Code _____ Cellphone No. _____

Date and Place of Birth _____ Age: _____ Gender _____ Citizenship _____

Civil Status _____ Religion _____ E-mail Add _____

Father _____ Occupation _____ Phone _____

Mother _____ Occupation _____ Phone _____

Guardian _____ Address _____ Phone _____

Elementary School _____ Year Graduated _____

High School _____ Year Graduated _____

College _____ Year Graduated _____

Pre-Med Course _____ Year Graduated _____

School Last Attended _____ School Year _____

Honors/Awards : _____

Give a candid evaluation of yourself, your strengths and weaknesses. (Use additional sheet if necessary)

What is the value of medical education to you? (Use additional sheet if necessary)

Who would fund your medical education?

How did you know of the St. Luke's College of Medicine - William H. Quasha Memorial?

Why St. Luke's College of Medicine? Please rank according to importance.

(1 = most important; 6 = least important)

Curriculum Scholarship Opportunity Facilities
 Reputation Career Opportunities Others _____

Have you applied in other medical school(s)?

[] No [] Yes _____
School _____ Status of Application _____

Have you ever been enrolled in other medical school(s)?

[] No [] Yes _____
School _____ Date/School Year _____

IF FOREIGN APPLICANT: ACR No. _____ VISA STATUS _____

IMPORTANT: The application for admission does not mean automatic acceptance to the College of Medicine.

I certify to the veracity of the above information, any evidence of fraud in the credentials/documents submitted will automatically nullify my enrollment in the College of Medicine.

I certify further that if accepted, I will abide by all the rules and regulations of the College and CHED.

OR No. _____
Signature of Applicant _____