



Application for Admission

Nonrefundable Application fee: \$45

Office of Admissions • 1423 N. Jefferson Avenue • Springfield, MO 65802
417/269-3401 • coxcollege.edu

Student Profile

Legal Name: _____
Last First Middle

Address: _____
Street City State Zip Code

County: _____ Birthplace: _____

E-Mail: _____ Home Phone: _____ Cell Phone: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Gender: Male Female
Month Day Year

Other Names Used (if applicable, this helps to locate received transcripts): _____

Citizenship

Are you a U.S. citizen? Yes No

Only persons who hold "permanent residence" status and meet the TOEFL score standard of at least 500 may apply.
Proof of permanent residency is required.

Behavioral History

Have you ever been convicted of a felony? Yes No

If yes, please indicate: _____
State Month / Year

Veteran Status

Are you a veteran or on active duty in the U.S. Armed Forces? Yes No

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Ethnic Information (Optional)

- White Hispanic of any race American Indian/Alaskan Native
- Black/African American Asian Race & Ethnicity unknown
- Nonresident Alien Two or more races Multi-Ethnic Native Hawaiian/other Pacific Islander

Enrollment Information

I plan to attend full time (12+ credit hrs) three-quarter time (9-11 credit hrs)
 half time (6-8 credit hrs) less than half time (0-5 credit hrs)

Financial Aid Information

Do you plan to file for the current year Free Application for Federal Student Aid (FAFSA)? Yes No

Employment Information

Are you a CoxHealth or CoxHealth affiliate employee? Yes No

Education Information

Name of High School _____ City _____ State _____ Graduation month/year _____

If not a high school graduate, have you earned the General Equivalency Diploma (GED)? Yes No
State: _____ Date: _____ Score: _____

Have you taken the ACT or SAT college entrance exams? Yes No

If yes, which test? ACT SAT Date: _____

Have you ever been dismissed or suspended from any college? Yes No

If yes: Name of College: _____ State: _____ Year: _____

Post-Secondary Education

List in chronological order, all post-secondary education institutions you attended.

Name of School	City and State	Dates Attended (Month/Year to Month/Year)	Degree Earned? (Yes/No)
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Program of Study

When do you plan to start classes? Fall (August) Spring (January) Summer (May) Year: _____

Please select **ONE** of the following choices.

- Associate of Science (ASN)
 - Associate of Science (ASN) – Advanced Placement (Licensed Practical Nurses only)
 - Bachelor of Science in Nursing (BSN)
 - Early Decision Option (high school junior or senior only)
 - RN to BSN Completion (for registered nurses who have a diploma or ASN degree)
 - BSN Accelerated (for graduates with a bachelor's degree in another discipline)
 - Associate of Science in Radiography (ASR)
 - Associate of Science in Medical Assisting (AS)
 - Medical Billing/Coding (Certificate)
 - Medical Transcription (Certificate)
 - Dietetic Internship (Certificate)
 - Diagnostic Imaging (Certificate)
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Applicant's Signature

The statements I have made in this application are correct to the best of my knowledge. I understand that any misrepresentation or omission of facts requested in this application is cause for disqualification for admission or for dismissal from Cox College. If admitted, I agree to conform to all rules and regulations of Cox College. I also agree to give Cox College permission to share results of background check and immunization records with clinical agencies.

Cox College does not discriminate on the basis of age, sex, color, disability, marital status, race, religion, ethnic or national origin. Any person having concerns with respect to rights; questions about reasonable accommodations; the existence and location of services, activities, and facilities that are accessible to and usable by persons with disabilities; or needs other information should contact the director of student services/section 504 coordinator, at Cox College, 1423 N. Jefferson Ave., Springfield, MO 65802; phone number 417-269-3598.

Signature

Date

Date application received/by: _____

File reviewed by: _____

Payment type: cash check charge money order

Date admitted: _____

Date application entered/by: _____