DOCTOR OF PHYSICAL THERAPY (DPT) PROGRAM
APPLICATION PACKET

Applications must be postmarked no later than January 13, 2014
for consideration in DPT enrollment beginning Summer 2014

Langston University
School of Physical Therapy
P.O. Box 1500
Langston, OK 73050

Phone: (405) 466-2925
Fax: (405) 466-3565

E-mail: scorbett@langston.edu
www.langston.edu/academics/physical_therapy.aspx
Dear Prospective Applicant,

Thank you for your expressed interest in the Doctor of Physical Therapy Program at Langston University. Enclosed please find the application packet. Please review the packet thoroughly. If you have any questions please call 466-2925 or e-mail scorbett@langston.edu. The faculty in the School of Physical Therapy is available to assist with advisement pertaining to enrollment in the Doctor of Physical Therapy program. The completed application materials and requested materials must be sent directly to the School of Physical Therapy. **Applications must be postmarked on or before January 13, 2014. All the information requested is to be mailed directly to:**

LANGSTON UNIVERSITY
Attn: Ms. Samantha Corbett
Administrative Assistant
School of Physical Therapy
P.O. Box 1500
Langston, Oklahoma 73050

Upon receipt of your application, we will send you a letter acknowledging that we have received the application. The DPT program accepts a maximum of fourteen students each year for the class that begins in the summer semester. The Selection and Admissions Committee utilizes a rolling admissions policy for 50% (7 students) of the fourteen qualified students to be selected. Qualified applicants are encouraged to submit all of the required documents as early as possible. Final selection will be completed by March 10, 2014.

Again, thank you for your interest in Langston University, School of Physical Therapy.

Sincerely,

Samantha Corbett
Administrative Assistant
School of Physical Therapy
Doctor of Physical Therapy Program
Langston University, School of Physical Therapy, is in compliance with Title IV and VII of the Civil Rights Act of 1964, Executive Order 11246 as amended, Title IX of the Education Amendments of 1972, Americans with Disabilities Act of 1990 and other federal laws and regulations. Langston University does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, or status as a veteran in any of its policies, practices, or procedures. This includes, but is not limited to, admissions, employment, financial aid, and educational services.

ACADEMIC PREPARATION
Applicants must have completed requirements for a baccalaureate degree at an accredited college or university with a minimum grade point average (GPA) of 3.0 on a scale of 4.0 in which 4.0 is equivalent to an “A”. The DPT Program specified prerequisite courses must be completed with a “C” or better grade in each course and an overall GPA of 2.5 for the prerequisite courses. Prerequisite courses must have been completed within the last 10 years.

APPLICATION PROCEDURES
- Submit a completed application for admission to the School of Physical Therapy, Doctor of Physical Therapy Program (DPT).
- Submit requests for official undergraduate and graduate transcript(s) to be sent directly from each institution attended to the School of Physical Therapy at Langston University.
- Request official undergraduate transcript from the baccalaureate degree conferring institution to be mailed directly to the School of Physical Therapy. Confirmation of baccalaureate degree must be received prior to enrollment in the DPT program. Official transcripts will also be evaluated to identify compliance with prerequisite courses needed for the DPT admissions process.
- Submit three recommendations from academic advisors or individuals who can address the potential for success of the applicant. Sealed recommendations are mailed directly to the School of Physical Therapy using the forms provided.
- Submit an autobiographical statement of no less than 500 words (and no more than 1000 words) following guidelines on the ‘Autobiographical Statement’ form.
- Submit scores from the Graduate Record Examination (GRE) directly to the School of Physical Therapy. All applicants are required to take the Graduate Record Examination (GRE). (Although the DPT program does not specify a minimum score requirement on the GRE, it is recommended that applicants score in the 50th percentile or better for each of the areas assessed by the GRE. GRE scores should date no longer than 5 years prior to date of application.)
- Submit documentation of 50 clinical observation hours with a licensed physical therapist.
- Attach a non-refundable application fee of ($50.00) for in-state applicants and ($75.00) for out-of-state.
- Upon receipt of the completed application and required documents qualified applicants will be notified of a date and time for an interview with the School of Physical Therapy Selection and Admissions Committee Members.
- Compliance with medical information and other Langston University requirements must be met prior to enrollment in the School of Physical Therapy DPT program of study.
APPLICATION CHECKLIST

Listed below is a check list of materials and documents that must be submitted to the School of Physical Therapy Selection and Admissions Committee on or before January 13, 2014. You should have all required materials mailed directly to the School of Physical Therapy. Carefully review your application to determine that all information is complete and accurate. An incomplete application or failure to submit required documents, and appropriate fee (check or money order) will delay processing.

- **Completed Application** to Langston University, School of Physical Therapy, Doctor of Physical Therapy Program
- **Autobiographical Essay**
- **Official transcripts** requested for undergraduate and graduate degrees/course work from each institution attended
- **3 Recommendation Letters**
- **Graduate Record Examination** (GRE) test results
- **Completed Medical History**
  - Part 1 and 2 of the medical history form
  - Urinalysis
  - Current Tuberculosis Test—annually
  - Compliance Forms (included in packet)
  - Immunization History—MUST INCLUDE MMR vaccine
  - Varicella 1&2 or titer
  - Hepatitis B Vaccine Series
- **Clinical Observation Documentation** (completed by a licensed physical therapist)
- **Confirmation of baccalaureate degree**
- **Non-refundable application fee** $50.00 (Oklahoma residents) $75.00 (out of state applicants)

**DEADLINE DATE: JANUARY 13, 2014**

MAIL ALL REQUESTED INFORMATION DIRECTLY TO:

**LANGSTON UNIVERSITY**
Attn: Ms. Samantha Corbett
Administrative Assistant
School of Physical Therapy
P.O. Box 1500
Langston, Oklahoma 73050
# APPLICATION FOR ADMISSION: Academic Year 20_______

1. **Applicant’s Full Legal Name:**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

2. **Other Names under which your records may appear:**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

3. **Social Security Number:**

4. **E-Mail:**

5. **Are you a veteran?**

- [ ] Yes
- [ ] No

If yes, what is your discharge date?

Information requested regarding applicant’s race or ethnicity is voluntary, and will be used in a non-discriminatory manner consistent with applicable civil rights laws.

6. **Gender:**

- [ ] Male
- [ ] Female

7. **Date of Birth:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

8. **Place of Birth:**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
</tr>
</thead>
</table>

9. **Race/Ethnic Background:**

- [ ] African American
- [ ] Asian American
- [ ] Hispanic
- [ ] White
- [ ] Native American
- [ ] Other:

10. **Citizenship/Residency:**

<table>
<thead>
<tr>
<th>Are you a citizen of the United States?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
</tr>
</tbody>
</table>

If no, country of citizenship

<table>
<thead>
<tr>
<th>If not a U.S. citizen, do you have permanent resident Alien status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
</tr>
</tbody>
</table>

If no, please complete an international student application.

If yes, please include a photocopy of your registration card (front & back).

<table>
<thead>
<tr>
<th>Are you an Oklahoma resident?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
</tr>
</tbody>
</table>

If yes, how long?

<table>
<thead>
<tr>
<th>In what county?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are not an Oklahoma resident, in what state are you a resident?</td>
</tr>
</tbody>
</table>

11. **Permanent Address:**

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

12. **Mailing Address:**

<table>
<thead>
<tr>
<th>Street</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

13. **Telephone Numbers:**

<table>
<thead>
<tr>
<th>Work</th>
<th>Home</th>
<th>Cellular</th>
</tr>
</thead>
</table>

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Page 1 of 3 – Application for Admission
14. Next of Kin:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Relationship</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

15. Address of Next of Kin:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

16. Did you previously attend Langston University?  □ Yes  □ No

If yes, when did you last attend?

17. Have you previously applied to the School of Physical Therapy?  □ Yes  □ No

If yes, what year(s)?

18. Have you taken the Graduate Record Examination?  □ Yes  □ No

If yes, date GRE was taken:

<table>
<thead>
<tr>
<th>Were scores sent to Langston?</th>
<th>□ Yes  □ No</th>
</tr>
</thead>
</table>

GRE comments

19. Are you currently on probation from any college or university?  □ Yes  □ No

If yes, please explain:

20. Have you ever been suspended or expelled from any college or university?  □ Yes  □ No

If yes, please explain:

21. Have you ever been convicted of a felony?  □ Yes  □ No

If yes, please explain:

22. Education History: Official transcripts from all institutions of higher education attended must be forwarded to the School of Physical Therapy

<table>
<thead>
<tr>
<th>School</th>
<th>Dates of Attendance</th>
<th>Degree</th>
<th>Date Awarded</th>
<th>Area of Concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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REQUIRED BY ALL APPLICANTS

By my signature below, I certify that:

1. The information provided is complete and accurate to the best of my knowledge.

2. I understand that Langston University requires official transcripts from EACH college I have attended, and I am responsible for ensuring that these transcripts are sent directly to Langston University.

3. I authorize any college or university I have attended to furnish transcripts and any other information as requested by Langston University.

4. I understand that by withholding information requested in this application or giving false information, I may be ineligible for admission to, or continued enrollment at Langston University.

5. I authorize the Selection and Admissions Committee to discuss information pertaining to the application process with those individuals providing transcripts, recommendations, and other documentation (including clinical observations).

______________________________  ________________________________  ________________
Signature                  Print Name                  Date

Carefully review your application to determine that all information is complete and accurate. An incomplete application or failure to submit required documents, and appropriate fee (check or money order) will delay processing. Please return completed application and fee directly to the School of Physical Therapy.
Supplement to the Application
PREREQUISITE COURSES & REQUIREMENTS COMPLETED

Please print or type the information requested

1. Applicant’s Full Legal Name:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

2. Social Security Number:

3. Physical Therapy Prerequisite Courses Completed: Please complete the grid below. If you plan to take the course in the future, state the semester the course will be completed. Evidence of course completion through official transcripts must be submitted and received in support of the application. **Note:** All prerequisites must have been completed within the last 10 years.

<table>
<thead>
<tr>
<th>Course</th>
<th>Semester was Completed</th>
<th>Number of Credits Received</th>
<th>Grade Received</th>
<th>School the Course was Completed at (abbreviation is fine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biology I</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biology II or Zoology</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Anatomy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physiology</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>*Anatomy &amp; Physiology I</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>*Anatomy &amp; Physiology II</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Chemistry I</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Chemistry II</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physics I</td>
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</tr>
<tr>
<td>Physics II</td>
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<tr>
<td>General Psychology</td>
<td></td>
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<tr>
<td>Child Development</td>
<td></td>
<td></td>
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<tr>
<td>English Composition</td>
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<td></td>
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<tr>
<td>Statistics</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medical Terminology</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* A two-semester course sequence of human anatomy and physiology can be substituted for one semester of anatomy and one semester of physiology coursework.

TO BE COMPLETED BY ALL APPLICANTS
Carefully review the supplement to the application to determine that all information is complete and accurate.

I authorize the admissions committee of the School of Physical Therapy to discuss information pertaining to the application process with those individuals providing transcripts, letters of recommendation, and documentation of clinical observations. I understand that withholding information requested in this application or giving false information, I may be ineligible for admission to, or continued enrollment in Langston University.

Applicants Signature

Date

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Pre-requisite Courses and Requirements
CLINICAL OBSERVATION DOCUMENTATION

Please print or type the information requested. Use ink only. Prior to mailing, be sure you have done the following: 1) Provided all information requested; 2) Verified your social security number; 3) Signed and dated this supplemental documentation; and 4) Attached all documents supporting observation hours. A total of 50 clinical observation hours is necessary. This form may be duplicated if necessary.

Year Applying for Entry: Summer 20_____

Applicant’s Full Legal Name: ___________________________ Last First Middle

Social Security Number: ______________________________

Facility Information: ___________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

Person Approving Hours: ___________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
</tr>
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</tbody>
</table>

Clinical Observation Record:

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Hours</th>
<th>Name, title and signature of supervisor*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(if differs from person approving hours)</td>
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</tbody>
</table>

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Clinical Observation Hours
RECOMMENDATION OF APPLICANT

To the Applicant: Please type or print in ink

Name: ____________________________

Last First Middle

Address: ____________________________

Street City, State Zip Code

Telephone: ____________________________

Home Work Cellular

Applicant Waiver:
Under the federal law entitled the Family Education and Rights and Privacy Act of 1974, individuals are given the right to inspect their records including letters of recommendation. However, we invite you, but do not require you, to sign the following waiver.

Student Signature __________________ Date __________

To The Individual Providing the Recommendation:
Thank you for assisting the graduate faculty in evaluating the above named applicant who is applying for admission to our Doctor of Physical Therapy program. We would appreciate your sincere assessment of the applicant. Please complete the recommendation form and mail directly to the School of Physical Therapy. Please seal the envelope and sign across the sealed flap.

1. How long have you known the applicant? ____ yrs. ____ mos. ☐ As a student ☐ Other

2. Letter of recommendation: May be included, describing specific qualities or talents of the individual as a supplement to this form, and would greatly enhance our assessment of the candidate’s qualities.

3. Using the qualities listed below, how would you rate the applicant on the following traits?

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Outstanding</th>
<th>Unable to Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Performance/Potential</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Personal Appearance</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Motivation/Career Goals</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Leadership Skills</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Verbal Skills</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Writing Skills</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Quantitative Skills</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Occupational Background Related Experience</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
4. Academic Rank and/or Job Performance (Check applicable ratings)

<table>
<thead>
<tr>
<th>Academic Rank:</th>
<th>☐ Top 10%</th>
<th>☐ Top 25%</th>
<th>☐ Top 50%</th>
<th>☐ Lower 50%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Job Performance:</th>
<th>☐ Top 10%</th>
<th>☐ Top 25%</th>
<th>☐ Top 50%</th>
<th>☐ Lower 50%</th>
</tr>
</thead>
</table>

5. Please discuss: the strengths and weaknesses you think may affect the applicant’s performance in graduate studies, especially in the chosen field.

6. Evaluation Summary (Please check an appropriate response):

☐ I strongly recommend the applicant for admission to the Graduate Program and feel the applicant has the potential to be an outstanding graduate student.

☐ I recommend the applicant for admission to the Graduate Program and feel the applicant will probably perform at an average or above level.

☐ Even though the qualifications of the applicant are marginal, I feel the applicant should be given the opportunity to pursue graduate study.

☐ I do not recommend the applicant for admission to the Graduate Program.

Recommender:

Name (print)  
Title

School/Organization  
Area Code - Telephone

Address  
City, State  
Zip Code

Recommender’s Signature  
Date

PLEASE RETURN TO:

Ms. Samantha Corbett
Langston University
School of Physical Therapy
P.O. Box 1500
Langston, OK 73050

Telephone: 405.466.2925  |  Fax: 405.466.3565

This form may be reproduced
RECOMMENDATION OF APPLICANT

To the Applicant: Please type or print in ink

Name: ____________________________

Last Name: ________________________
First Name: ________________________
Middle Name: ______________________

Address: ____________________________
Street: ____________________________
City, State: ________________________
Zip Code: __________________________

Telephone: ____________________________
Home: ________ Work: ________ Cellular: ________

Applicant Waiver:
Under the federal law entitled the Family Education and Rights and Privacy Act of 1974, individuals are given the right to inspect their records including letters of recommendation. However, we invite you, but do not require you, to sign the following waiver.

Student Signature: ____________________________ Date: __________

To The Individual Providing the Recommendation:
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3. Using the qualities listed below, how would you rate the applicant on the following traits?

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<th>Average</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Academic Performance/Potential</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Personal Appearance</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Motivation/Career Goals</td>
<td>□</td>
<td>□</td>
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<td>□</td>
<td>□</td>
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<tr>
<td>Leadership Skills</td>
<td>□</td>
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<td>□</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Verbal Skills</td>
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4. Academic Rank and/or Job Performance (Check applicable ratings)

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5. Please discuss: the strengths and weaknesses you think may affect the applicant’s performance in graduate studies, especially in the chosen field.

6. Evaluation Summary (Please check an appropriate response):

- ☐ I strongly recommend the applicant for admission to the Graduate Program and feel the applicant has the potential to be an outstanding graduate student.

- ☐ I recommend the applicant for admission to the Graduate Program and feel the applicant will probably perform at an average or above level.

- ☐ Even though the qualifications of the applicant are marginal, I feel the applicant should be given the opportunity to pursue graduate study.

- ☐ I do not recommend the applicant for admission to the Graduate Program.

Recommender:

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<th>Zip Code</th>
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</table>

Recommender's Signature | Date

PLEASE RETURN TO:

Ms. Samantha Corbett
Langston University
School of Physical Therapy
P.O. Box 1500
Langston, OK 73050

Telephone: 405.466.2925 | Fax: 405.466.3565

This form may be reproduced
RECOMMENDATION OF APPLICANT

To the Applicant: Please type or print in ink

Name: _______________________________ _______________________________ _______________________________

Last First Middle

Address: _______________________________ _______________________________ _______________________________

Street City, State Zip Code

Telephone: _______________________________ _______________________________ _______________________________

Home Work Cellular

Applicant Waiver:
Under the federal law entitled the Family Education and Rights and Privacy Act of 1974, individuals are given the right to inspect their records including letters of recommendation. However, we invite you, but do not require you, to sign the following waiver.

Student Signature _______________________________ Date _______________________________

To The Individual Providing the Recommendation:
Thank you for assisting the graduate faculty in evaluating the above named applicant who is applying for admission to our Doctor of Physical Therapy program. We would appreciate your sincere assessment of the applicant. Please complete the recommendation form and mail directly to the School of Physical Therapy. Please seal the envelope and sign across the sealed flap.

1. How long have you known the applicant? ____ yrs. _____ mos. □ As a student □ Other

2. Letter of recommendation: May be included, describing specific qualities or talents of the individual as a supplement to this form, and would greatly enhance our assessment of the candidate’s qualities.

3. Using the qualities listed below, how would you rate the applicant on the following traits?

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Page 1 of 2 – Recommendation of Applicant
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☐  I do not recommend the applicant for admission to the Graduate Program.

Recommender:

Name (print)        Title

School/Organization       Area Code - Telephone

Address        City, State        Zip Code

Recommender’s Signature        Date

PLEASE RETURN TO:

Ms. Samantha Corbett
Langston University
School of Physical Therapy
P.O. Box 1500
Langston, OK 73050

Telephone: 405.466.2925 | Fax: 405.466.3565

This form may be reproduced
Instructions to the applicant: Please complete an autobiographical statement that describes why you want to pursue graduate professional education at Langston University in the field of physical therapy leading to the Doctor of Physical Therapy degree. The statement should be in narrative form and should be a minimum of 500 words, not to exceed 1,000 words. The composition of the essay must be original and must not be edited by anyone other than the applicant. The statement must be typed and included with the application at the time of submission. Your thoughts should be well organized, well written, and convey the following: 1) Why you desire to attend Langston University, School of Physical Therapy, Doctor of Physical Therapy program; 2) How your undergraduate education has prepared you for professional graduate education; and 3) Your aspirations and future contributions in the doctoring profession of physical therapy.

Please sign the following and submit with the autobiographical statement.

I, __________________________________________, submit the following autobiographical statement to Langston University, School of Physical Therapy, Selection and Admissions Committee for review in partial fulfillment of the application requirements for the Doctor of Physical Therapy degree program. I understand that the contents of the essay will be shared in a confidential manner with the Selection and Admissions Committee members. I acknowledge that the information provided is accurate and was written by me independent of assistance from others.

__________________________________________
Applicant’s Signature

__________________________________________
Date

__________________________________________
Print Full Name

Autobiographical Statement

Langston University, School of Physical Therapy, is in compliance with Title IV and VII of the Civil Rights Act of 1964, Executive Order 11246 as amended, Title IX of the Education Amendments of 1972, Americans with Disabilities Act of 1990 and other federal laws and regulations. Langston University does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, or status as a veteran in any of its policies, practices, or procedures. This includes, but is not limited to, admissions, employment, financial aid, and educational services.
Meningococcal Disease

The State of Oklahoma has enacted a new immunization requirement for college and university students.

Effective with the Fall 2004 semester, all new students, (including transfer students and graduate students), are required to comply with Section 3243 of Oklahoma Statutes Title 70. This requires that students who live in housing comply with one of the following options:

- Option A: Be immunized for meningococcal disease

  OR

- Option B: After having reviewed information about meningitis provided by Langston University, decline the vaccination.

These choices will be part of the housing contract provided by Langston University Residence Life and must be completed prior to being allowed to move in housing.
Official Notice: Immunization Requirements for Langston University Students

Beginning with the fall semester 2004, Oklahoma state law requires that all new students who attend Oklahoma colleges and universities for the first time provide proof of immunization for certain diseases. If you cannot verify your immunizations you will need to be re-immunized. Medical, religious and personal exemptions are allowed by law and such requests must be made in writing using the Langston University Certificate of Exemption form.

Acceptable documentation of Immunizations includes any of the following:

- Signature of a physician or nurse on this form, page 4, verifying the accuracy of submitted information.
- Copies of shot records.
- Copies of medical records.
- Copies of school health records.
- Copies of laboratory test results demonstrating immunity.

Immunizations Required by State Law

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Who must comply</th>
<th>Compliance Requirements</th>
<th>Compliance Date</th>
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</thead>
<tbody>
<tr>
<td>Meningitis*</td>
<td>All new students living in Campus housing</td>
<td>Proof of vaccination or signed declination</td>
<td>At move in</td>
</tr>
<tr>
<td>Measles, Mumps</td>
<td>All new students born after after January 1, 1957</td>
<td>Proof of vaccination with 2 doses of vaccine; or lab test demonstrating immunity; or, signed Certificate of Exemption</td>
<td>End of the fourth week of classes</td>
</tr>
<tr>
<td>Rubella, TWO DOSES</td>
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</tr>
<tr>
<td>Hepatitis B</td>
<td>All new students</td>
<td>Proof of completion of a Hep B Series or signed Certificate of Exemption</td>
<td>Minimum of first 2 shots by 6th week of class; completion of series by 4th week of the students semester</td>
</tr>
</tbody>
</table>

*Specific information regarding immunization for meningitis:
Oklahoma Law requires that first time enrollees who reside in on-campus student housing be vaccinated against meningococcal disease UNLESS, 1) the individual signs a written waiver that he/she has reviewed the information provided by Langston University regarding meningitis immunization and has chosen not to be immunized, or, 2) in the case of a minor, the individual’s parent or guardian signs such written waiver.

FAILURE TO COMPLY WITH THESE REQUIREMENTS WILL RESULT IN A HOLD BEING PLACED ON FUTURE ENROLLMENT

Some required immunizations are available at the University Medical Center

Certain students are also required to comply with Langston University requirements for tuberculosis testing.

Please mail original completed forms to:
Langston University
School of Physical Therapy
P.O. Box 1500
Langston, Oklahoma 73050
(405) 466-2925  FAX (405) 466-3565

All original documents will be submitted to the Langston University Medical Center by the School of Physical Therapy admissions officer.
Information Regarding Tuberculosis Testing

All new students at Langston University are required to comply with a Tuberculosis testing policy. This policy affects all students based on residency and health status. This policy requires all students who meet any of the criteria below to provide evidence of having been tested for Tuberculosis within the six months prior to coming to Langston, OR by the fourth week of classes.

Who Must Comply

- Students currently holding a visa from U.S. Immigration Service
- A student who is a U.S. citizen currently or previously residing outside the U.S.
- Students with a health/medical condition that suppresses the immune system
- Students with known exposure to someone with active tuberculosis disease

If any of these apply to you, you will need to comply with the Tuberculosis testing requirement. For other students, this is a recommendation.

TO COMPLY:

Provide a medical record in English from a physician, clinic or hospital indicating that you have been tested for Tuberculosis or provide documentation of a negative chest x-ray within the previous 6 months. These records must include the date of the test(s) and the results of the test(s).

The following procedure for the skin test must be used.

0.1 ml of Purified Protein Derivative, (Mantoux), solution intradermally to the inner forearm.

Results must be read within 48-72 hours of administration. Documentation must include date given, date read and results in mm. Please document zero mm if no reaction.

OR

Submit to a TB skin test at University Health Services during the first four weeks of the semester.

OR

Provide a medical record indicating successful treatment for TB disease.

Please note: Having received BCG vaccination does NOT exempt you from the testing requirement. If you have had a positive skin test, a chest x-ray is required to show the absence of active disease. Failure to comply may prevent enrollment for your next semester.
WHAT YOU NEED TO KNOW ABOUT MENINGITIS:

What is Meningitis?
- Meningitis is a rare but potentially fatal bacterial infection.
- It can occur in two forms as either meningococcal meningitis, an inflammation that affects the brain and spinal cord, or as meningococcemia, the pressure of bacteria in the blood.
- Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure, or death can result from the infection.

What causes Meningitis?
- This infection is caused by the bacterium Neisseria meningitides, a leading cause of bacterial meningitis in older children and young adults in the U.S.

How is Meningitis transmitted?
- Meningococcal bacteria are transmitted through air droplets and direct contact with persons already infected with the disease.
- Direct contact also occurs with shared items, such as cigarettes or drinking glasses, or through intimate contact such as kissing.

Is there a vaccine to help prevent Meningitis?
- A safe, effective vaccine is available.
- The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A,C,Y, and W-135) that cause about 70% of disease in the U.S.
- The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days.
- After vaccination, immunity develops within 7 to 10 days and remains effective for any vaccine; vaccination against meningitis may not protect 100% of all susceptible individuals.

What are the early symptoms of Meningitis?
- High fever
- Rash
- Vomiting
- Severe Headache
- Neck stiffness
- Lethargy
- Nausea
- Sensitivity to light
- Meningitis usually peaks in late winter and early spring, overlapping flu season, and symptoms can easily be mistaken for the flu
- Because the infection progress quickly, students should seek medical care immediately if 2 or more of these symptoms occur at one time
- If untreated, meningitis can lead to shock and death within hours of the first symptom

Who is at risk?
- College students, particularly freshmen who live in campus residence halls.
- Anyone in close contact with a known case
- Anyone with an upper respiratory infection, with a compromised immune system
- Anyone traveling to endemic areas of the world where meningitis is prevalent.
**VACCINES**

**WHAT YOU NEED TO KNOW**

1. Why get vaccinated?

Measles, mumps, and rubella are serious diseases.

- Measles
  - Measles virus causes rash, cough, runny nose, eye irritation, and fever.
  - It can lead to ear infection, pneumonia, seizures (jerking and staring), brain damage, and death.

- Mumps
  - Mumps virus causes fever, headache, and swollen glands.
  - It can lead to deafness, meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, and rarely, death.

- Rubella (German Measles)
  - Rubella virus causes rash, mild fever, and arthritis (mostly in women).
  - If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

You or your child could catch these diseases by being around someone who has them. They spread from person to person through the air.

Measles, mumps, and rubella (MMR) vaccine can prevent these diseases.

Most children who get their MMR shots will not get these diseases. Many more children would get these diseases. Many more children would get these diseases if we stopped vaccinating.

2. Who should get MMR Vaccine and when?

Children should get 2 doses of MMR vaccine:

- The first at 12 – 15 months of age
- The second at 4 - 6 years of age.

These are the recommended ages, but children can get the second dose at any age, as long as it is at least 28 days after the first dose.

Some adults should also get MMR vaccine:

- Generally, anyone 18 years of age or older, who was born after 1956, should get at least one dose of MMR vaccine, unless they can show that they have had either the vaccines or the diseases.

Ask your doctor or nurse for more information

MRR vaccine may be given at the same time as other vaccines.

3. Some people should not get MMR vaccine or should wait

- People should not get MMR vaccine who have ever had a life-threatening allergic reaction to gelatin, the antibiotic neomycin, or a previous dose of MMR vaccine.

- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting MMR vaccine.

- Pregnant women should wait to get MMR vaccine until after they have given birth. Women should avoid getting pregnant for 4 weeks after getting MMR vaccine.

- Some people should check with their doctor about whether they should get MMR vaccine, including anyone who:
  - Has HIV/AIDS, or another disease that affects the immune system
  - Is being treated with drugs that affect the immune system, such as steroids, for 2 weeks or longer.
  - Has any kind of cancer
  - Is taking cancer treatment with x-rays or drugs
  - Has ever had a low platelet count (a blood disorder)

- People who recently had a transfusion or were given other blood products should ask their doctor when they may get MMR vaccine.

Ask your doctor or nurse for more information.

4. What are the risks from MMR vaccine

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of MMR vaccine causing serious harm, or death, is extremely small.

Getting MMR vaccine is much safer than getting any of these three diseases.

Most people who get MMR vaccine do not have any problems with it.

- Mild Problems
  - Fever (up to 1 person out of 6)
  - Mild rash (about 1 person out of 20)
  - Swelling of glands in the cheeks or neck (rare)

If these problems occur, it is usually within 7-12 days after the shot. They occur less often after the second dose.

- Moderate Problems
  - Seizure (jerking or staring) caused by fever (about 1 out of 3,000 doses)
  - Temporary pain and stiffness in the joints, mostly in teenagers or adult women (up to 1 out of 4)
  - Temporary low platelet count, which can cause a bleeding disorder (about 1 out of 30,000 doses)

5. What if there is a moderate or severe reaction?

What should I look for?

- Any unusual conditions, such as a serious allergic reaction, high fever or behavior changes. Signs of a serious allergic reaction include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness within a few minutes to a few hours after the shot. A high fever or seizure, if it occurs, would happen 1 or 2 weeks after the shot.

- What should I do?
  - Call a doctor, or get the person to a doctor right away.
  - Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
  - Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Reporting System (VAERS) form. Or call VAERS yourself at 1-800-822-7967 or visit their website at http://www.vaers.org

6. The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help you pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit the program’s website at http://www.hrsa.gov/nvic

7. How can I learn more

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-2522 (English)
  - Call 1-800-232-0233 (Spanish)
- Visit the National Immunization Program’s website at http://www.cdc.gov/nip
1. Why get vaccinated?
Hepatitis B is a serious disease.

The hepatitis B virus (HBV) can cause short-term (acute) illness that leads to:
- Loss of appetite
- Diarrhea
- Vomiting
- Fever
- Headache
- Fatigue
- Muscle pain
- Nausea
- Jaundice (yellow skin or eyes)
- It can also cause long-term (chronic) illness that leads to:
  - Liver damage (cirrhosis)
  - Liver cancer
  - Death

About 1.25 million people in the U.S. have chronic HBV infection.

Each year it is estimated that:
- 80,000 people, mostly young adults, get infected with HBV
- More than 11,000 people have to stay in the hospital because of hepatitis B
- 4,000 to 5,000 people die from chronic hepatitis B

Hepatitis B vaccine can prevent hepatitis B. It is the first anti-cancer vaccine because it can prevent a form of liver cancer.

2. How is hepatitis B virus spread?
Hepatitis B virus is spread through contact with the blood and body fluids of an infected person. A person can get infected in several ways, such as:
- by having unprotected sex with an infected person
- by sharing needles when injecting illegal drugs
- by being stuck with a used needle on the job
- during the birth when the virus passes from an infected mother to her baby

About 1/3 of people who are infected with hepatitis B in the United States don’t know how they got it.

3. Who should get hepatitis B vaccine and when?

1) Everyone 18 years of age and younger
2) Adults over 18 who are at risk

Adults at risk for HBV infection include:
- people who have more than one sex partner in 6 months
- men who have sex with other men
- sex contacts of infected people
- people who inject illegal drugs
- health care and public safety workers who might be exposed to infected blood or body fluids
- household contacts of persons with chronic HBV infection
- hemodialysis patients

4. Some people should not get hepatitis B vaccine or should wait.

People should not get hepatitis B vaccine if they have ever had a life-threatening allergic reaction to baker’s yeast (the kind used for making bread) or to a previous dose of hepatitis B vaccine.

People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting hepatitis B vaccine.

Ask your doctor or nurse for more information.

5. What are the risks from hepatitis B vaccine

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of hepatitis B vaccine causing serious harm, or death, is extremely small.

Getting hepatitis B vaccine is much safer than getting hepatitis B disease.

Most people who get hepatitis B vaccine do not have any problems with it.

6. What if there is a moderate or severe reaction

What should I do?
- Call a doctor or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
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8. How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department’s immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call –1-800-232-2522 or 1-888-443-7232 (English)
  - Call 1-800-232-0233 (Espanol)
- Visit the National Immunization Program’s website at http://www.cdc.gov/nip or CDC’s Division of Viral Hepatitis website at http://www.cdc.gov/hepatitis
All new students must complete both pages of this form

Medical History (Part 1)

P.O. Box 1500
Langston, OK 73050
405.466.3335

Please indicate the first semester you will attend:
- Fall 20____
- Spring 20____
- Summer 20____

Name:

<table>
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<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Male</th>
<th>Female</th>
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Social Security # or I.D. #:
Date of Birth:

- Citizenship U.S.
- Other (Specify)

EMERGENCY CONTACT INFORMATION

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<th>Relationship</th>
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MEDICAL HISTORY – Have you ever had any of the following: (check if applicable)

- Alcohol Abuse
- Back Problems
- Convulsions/Seizures
- Drug Abuse
- Headache Chronic/Migraine
- High Blood Pressure
- Intestinal/Stomach Disorders
- Menstrual Problems/Pains
- Psychological Counseling
- Loss of Consciousness/Fainting
- Positive TB Skin Test
- Chronic Sinus Infections
- Anemia
- Chronic Cough
- Depression
- Eating Disorder
- Heart Disease
- High Cholesterol
- Malaria
- Orthopedic Problems
- Sickle Cell Disease
- Sleep Disorder
- Thyroid Disease
- Chicken Pox

- Arthritis
- Cancer
- Depression
- Chronic Cough
- Head Disease
- Heart Murmur
- Kidney Disease
- Pneumonia
- Rheumatic Fever
- Stroke
- Chronic Bladder/Urinary Infections

Brief explanation of any POSITIVE responses:

History of Surgery: □ Yes □ No Ongoing Medical Problems: □ Yes □ No (If yes, list below)

Environmental Allergies:

Medication Allergies: □ Yes □ No (List Medication/Reaction)

List Current Medications:

Herbs:

Tobacco Use: □ Yes □ No Type: Frequency:

ALL INFORMATION PROVIDED IS CONFIDENTIAL

To the physician: Please read the Health History on the first page and comment on any condition which you consider significant. Immunization against tetanus and polio should be recent enough to be effective. All tests must be given and the results recorded.
# Physical Examination (Part 2)

(to be filled in by physician)

Name: ___________________________ Date: ____________________

## Measurements and Other Findings

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<th>Color/Eyes</th>
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## Clinical Evaluation

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<td>Notes - Describe every abnormality in detail. (Enter pertinent number before each comment; continue and use additional sheets if necessary).</td>
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<td>Ears (general)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye (general)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharynx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Laboratory Findings

<table>
<thead>
<tr>
<th>Urinalysis:</th>
<th>Albumin</th>
<th>Sugar</th>
<th>Microscopic</th>
<th>Hematocrit</th>
<th>Hemoglobin (women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(required)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB Skin Test</td>
<td></td>
<td></td>
<td></td>
<td>Results of other pertinent laboratory tests &amp; X-rays</td>
<td></td>
</tr>
<tr>
<td>(Tine or PPD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Immunization History

<table>
<thead>
<tr>
<th>Initial Series</th>
<th>Most Recent Booster</th>
<th>Other Immunizations-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Information or Comments:

Do you consider this person in satisfactory health to pursue his or her studies? □ Yes □ No

Four hours of physical education are required for graduation.

Do you consider the applicant physically fit for physical exercise? □ Yes □ No

Limited exercise? □ Yes □ No

Signed: 

Signature of licensed physician: ___________________________ Date: ____________________

Name typed or printed: ___________________________

Mail Directly To:
Langston University
School of Physical Therapy
P.O. Box 1500
Langston, OK 73050

Any exception to completion of this application may be obtained from the Vice President of Student Affairs
CERTIFICATE OF EXEMPTION

Name of Student (please print) ______________________________________
Date of Birth ___________________________ Name of University
________________________________________
City ______________________________________ State ________ Zip
________________________________________
Social Security Number ________________________

TYPE OF EXEMPTION

1. MEDICAL CONTRAINDICATION:
I hereby certify that the immunization(s) specified below are medically contraindicated for
Named student.

Immunization(s) ___________________________ Immunization(s) ___________________________

Specify Contraindications _____________________________________________________________

Signature of Physician __________________________

2. RELIGIOUS OBJECTION:
I hereby certify that immunization is contrary to the teachings of the above named student’s religion.

Signature of student or parent if student is a minor __________________________ Date: ____________

3. PERSONAL OBJECTION:
I hereby certify that immunization is contrary to my beliefs. I request an exemption to the immunization requirements
for Oklahoma colleges and universities. I have written a brief summary of my objections in the space provided below.
I understand that lost records are not grounds for an exemption. I also understand that in the event of a disease
outbreak at the university, I may have to be excluded for my protection and for the protection of other students at the
university.

Briefly summarize your objections in this space: ____________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Signature of student or parent if student is a minor __________________________ Date: ____________

4. Please check which immunizations this exemption applies to:

☐ MMR (Measles, Mumps and Rubella) ☐ Hepatitis B
☐ Polio ☐ DtaP/TD (diphtheria, Tetanus & Pertussis)
☐ Meningitis (for students living in Residence Halls only) ☐ All

Signature of student or parent if student is a minor __________________________ Date: ____________

Mail directly to: Langston University, School of Physical Therapy, P.O. Box 1500, Langston, OK 73050
In Compliance with Oklahoma Statutes, Title 70 §3242
Certification of Menigococcal Compliance

Oklahoma Statutes, Title 70 §3242, requires that all students who are first time enrollees in any public or private postsecondary educational institution in this state and who reside in on-campus student housing shall be vaccinated against meningococcal disease. Institutions of higher education must provide the student or the student’s parent or other legal representative detailed information on the risks associated with meningococcal disease and on the availability and effectiveness of any vaccine.

The statute permits the student or, if the student is a minor, the student’s parent or other legal representative, to sign a written waiver stating that the student has received and reviewed the information provided on the risks associated with meningococcal disease and on the availability and effectiveness of any vaccine, and has chosen not to be or not to have the student vaccinated.

Student’s Name: ________________________________________________________________

Institution: ____________________________________________________________________

Birth date: ____________________ Term/Year of first Enrollment: _____________________

Social Security Number or Student ID: ______________________________________________

1) I have received and reviewed detailed information on the risks associated with meningococcal disease, and
2) I have received and reviewed information on the availability and effectiveness of any vaccine (against meningococcal disease), and
3) I have been vaccinated or I choose not to be vaccinated* against meningococcal disease.

Signature: ___________________________ Date: ______________________

When a student is under 18 years of age, the following also must be completed:

As the parent, guardian or other legal representative, I certify that the student named above is a minor and that I have received and reviewed the information provided and that I have chosen not to have the student vaccinated against meningococcal disease.

Signature: ___________________________ Date: ______________________

*With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless Langston University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized against meningitis.

Mail directly to: Langston University, School of Physical Therapy, P.O. Box 1500, Langston, OK 73050
In Compliance with Oklahoma Statutes, Title 70 §3243

Certification of Compliance
Hepatitis B, Measles, Mumps and Rubella (MMR)

Oklahoma Statutes, Title 70 §3243, requires that all students who enroll as a full-time or part-time student in an Oklahoma public or private postsecondary institution provide documentation of vaccinations against hepatitis B, measles, mumps and rubella (MMR).

The statute requires that Institutions notify students of the vaccination requirements and provide students with educational information concerning hepatitis B, measles, mumps and rubella (MMR), including the risks and benefits of the vaccination.

This statute permits that when the vaccine is medically contraindicated and a licensed physician has signed a written statement to that effect, such student shall be exempt from the vaccination. Further, the statute permits a student or if the student is a minor, the student’s parent or other legal representative, to sign a written waiver stating that the administration of the vaccine conflicts with the student’s moral or religious tenets.

Student’s Name: ____________________________________________________________

Institution: __________________________________________________________________________

Birth date: ________________ Term/Year of enrollment: ________________

Social Security Number or Student ID: ________________________________

1) I have been notified by my institution of the requirement that I must provide documentation of having received vaccinations against hepatitis B, measles, mumps and rubella (MMR), and

2) I have received and reviewed the educational information provided by my institution concerning hepatitis B, measles, mumps and rubella (MMR), including the risks and benefits of the vaccination, and

3) Further, I certify that: (Place a check in the applicable space below)

  _____ I have been vaccinated and have attached documentation in support as required by
  Oklahoma Statute, Title 70 §3243, or
  _____ I am exempt from the requirement and have attached a written statement from a licensed
  physician, which indicates that a vaccine is medically contraindicated, or
  _____ The administration of the vaccine conflicts with my moral or religious tenets.

Signature: _______________________________ Date: _______________________________

When a student is under 18 years of age, the following must be completed:

As the parent or other legal representative, I certify that the student named above is a minor and that the administration of the vaccine conflicts with my moral or religious tenets.

Signature: _______________________________ Date: _______________________________