HAMPTON UNIVERSITY
SCHOOL OF PHARMACY

Application Supplement

Applying for Term Beginning Fall, 20____

This application supplement must be received along with the University application and all other required information by the January 15 deadline. Failure to accurately, completely and truthfully execute the application and its supplement will result in the cancellation of admission and /or expulsion from the School of Pharmacy. Your application for admission to the School of Pharmacy will not be complete without this supplement.

(Please Type or Print in Black or Blue Ink)

Name: ___________________________________ (last 4 digits of SSN)____________________

Address: ____

City, State, Zip Code: _______________________________ Date of Birth: ________________

Gender: ____ Male ____ Female Email address___________________________________

Phone: (cell) ____________________________ (home) _________________________________

Nation of Citizenship: ___________________ State of Residency: ________________________

Ethnicity: (please check one)

African-American _____

White, Non-Hispanic _____

Native American _____

African _____

Asian _____

Hispanic _____

Other _________________________

Have you previously attended another School of Pharmacy? Yes__ No___

If yes, school______________________, dates of attendance_____________________________.

Have you ever been convicted of a felony? ___ If yes, please give details: ______________

____

Do you have any Board of Pharmacy action against you pending or resolved? _________
If yes, give details:

____

____

University/College in which you are currently enrolled:
(Please list the full name of the institution.)

____

Prior School Attendance

Please list below, in chronological order, every college, university, trade or technical school you have ever attended and all degrees earned (or that you expect to earn), including Associate Degree(s). If a degree was not earned, leave section empty. Use additional sheets if necessary.

Name of School	Location	Dates of Attendance From/To	Degree(s) Earned/Expected

List all courses taken during the fall and spring semesters the year prior to requested enrollment at Hampton University. If not currently taking any classes, please check the box below.

[ ] Not taking classes the year prior to enrollment.

Courses in Progress

College:_________________ Term:______		
Course No.	Course Title	Sem./Qtr. Hrs.
Total Hours:		

College:_________________ Term:______		
Course No.	Course Title	Sem./Qtr. Hrs.
Total Hours:		

At the close of each of the above sessions, please request that the Registrar's Office at the institution you are attending forward an official copy of your transcript(s) to Hampton University, School of Pharmacy, Office of Academic and Student Affairs, Hampton, VA 23668. Please be advised that we do not make exceptions for the late arrival of any admissions material and/or transcripts.

Will on campus housing be required? ___Yes ___No

PERSONAL STATEMENT

NAME: ____ SS#: __________________
First MI Last

Please type a personal statement about your goals relative to pharmacy. Also include any information that you feel to be important in evaluating your application to the School of Pharmacy. You may attach your personal statement to this form. Do not exceed one page in length. Please sign the bottom of your statement attesting to ownership.

____
Signature

Revised 7/03/12