



# DESTINY UNIVERSITY

School of Medicine and Health Sciences  
Saint Lucia W.I

## Application Form

Please complete **ALL** sections of this application form and include 2 Passport Photo's. A \$50 (US) Application Fee (non-refundable) must be submitted with this form. Checks made payable to: "**Destiny University**".

**Include with your application a personal statement describing why you would like to become a Physician. Please also include your Curriculum Vitae (Resume) with the application if available.**

Mail the completed Application Form and any other pertinent documents to:

**Destiny University  
School of Medicine and Health Sciences  
U.S. Information Office  
65 East Broadway Street  
Butte, MT 59701**

Phone: 406-533-6760  
Toll Free: 800-448-4008  
Fax: 406-782-2166

**Passport Photo**

**The Reverse of the  
Photograph  
Must be signed**

Name: \_\_\_\_\_

- Doctor of Medicine (MD) Program
- Master of Science (MS) Degree  
In Clinical Anatomy

# Personal Information:

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Social Security/National ID #: \_\_\_\_\_ Country Issued: \_\_\_\_\_

Date of Birth Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Driver License Number: \_\_\_\_\_ Where Issued: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_

Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ email Address: \_\_\_\_\_

Marital Status:  Single  Married

Gender:  Male  Female

Country of Citizenship: \_\_\_\_\_ Nationality: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Have you ever been convicted of a crime?  Yes  No

Have you ever been suspended, dismissed or forcibly withdrawn from an educational institution?

Yes  No

## Educational Information:

Type of Admission:  New Applicant  Transfer Applicant

MCAT Taken? (Not Required):  Yes  No

Date MCAT taken: \_\_\_\_\_

MCAT Score: \_\_\_\_\_

Overall Grade Point Average: \_\_\_\_\_ Science Grade Point Average: \_\_\_\_\_

## College(s) attended:

1. School: \_\_\_\_\_

City/State/Country: \_\_\_\_\_

Dates: \_\_\_\_\_ Major: \_\_\_\_\_

Degree(s) earned: \_\_\_\_\_ GPA: \_\_\_\_\_

2. School: \_\_\_\_\_

City/State/Country: \_\_\_\_\_

Dates: \_\_\_\_\_ Major: \_\_\_\_\_

Degree(s) earned: \_\_\_\_\_ GPA: \_\_\_\_\_

3. School: \_\_\_\_\_

City/State/Country: \_\_\_\_\_

Dates: \_\_\_\_\_ Major: \_\_\_\_\_

Degree(s) earned: \_\_\_\_\_ GPA: \_\_\_\_\_

4. School: \_\_\_\_\_

City/State/Country: \_\_\_\_\_

Dates: \_\_\_\_\_ Major: \_\_\_\_\_

Degree(s) earned: \_\_\_\_\_ GPA: \_\_\_\_\_

## Indicate courses you have completed below:

- Inorganic or General Chemistry
- Organic Chemistry
- General Biology or Zoology
- Advanced Biology and Chemistry
- Physics
- College-level Mathematics
- English

- Original Transcripts/Official Documents are required from all Colleges and Universities that were attended.
- For Transfer Students: If transcripts are unavailable or if more than four years have elapsed since course(s) were completed, a challenge examination may be required.

## Which program best fits your needs?

1.  Full-Time-On Campus MD Program
2.  Online Independent Study MD Program (partial online for Healthcare Professionals)
3.  Masters of Science (MS) in Clinical Anatomy (On-campus or Independent Study)

## Please indicate your health care background if applicable:

1. Physician Assistant
2. Nurse Practitioner
3. Doctor of Podiatry
4. Dentistry/Oral Surgery
5. Chiropractic
6. Doctor of Veterinary Medicine
7. Doctor of Osteopathic Medicine

Other (Please state): \_\_\_\_\_

## Application processing fee:

A \$50 processing fee must accompany this form.

Check/Money Orders should be made payable to "Destiny University".

## How did you hear of Destiny?

- Destiny (student, alumni, faculty)     Career/Pre-Health Advisor
- Internet Search     Google     MSN     Yahoo     Other Search
- E-mail     Campus Poster     College/Career Fair
- Brochure/Flyer     Other

## Required Professional Recommendations:

List the name, address, telephone number, of three (3) Professionals that will be submitting recommendations in support of your application. These **required** recommendations may be sent with the application or separately.

- Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_
- Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_
- Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**I attest to the accuracy of the statements made by me on this Application, and I understand by signing, any false statements or omissions may result in invalidation of my application or in dismissal from Destiny University.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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Phone: 800-448-4008  
Fax: 406-782-2166

### STUDENT MEDICAL REPORT

To be completed by a licensed practicing physician and sent to the above address.

Student Name: \_\_\_\_\_

Student Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**Physician:** Please complete the following:

Has the student had or currently experiencing any of the following diseases?

- |                           |                              |                             |
|---------------------------|------------------------------|-----------------------------|
| Allergy                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any Mental Illness        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any Communicable Diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Any other illness that may impact on his/her ability to successfully undertake Medical School:

\_\_\_\_\_

Additional comments: \_\_\_\_\_

**Examining Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Board Certification(s):** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_