



## Verification of Good Standing Form

This form should ONLY be completed and submitted if an applicant needs to provide proof of Good Standing in a Nursing and/or Health Science program that the applicant did not graduate/complete.

Verification of Good Standing Forms must be completed using the following directions:

1. Applicant must complete the 'Applicant Waiver' section before submitting the form for completion.
2. Verification of Good Standing Forms must be completed by the program Director/Department Chair.
3. Completed form must be returned to applicant to submit when applying to TJC Dental Assisting.

### APPLICANT WAIVER

This area must be completed by the applicant PRIOR to submitting the form for completion.

Pursuant to the Family Education Rights and Privacy Act (Buckley Amendment) enacted on December 31, 1974, I do do not] waive the right to inspect and review this completed 'Verification of Good Standing Form'. Applicant Printed Name: \_\_\_\_\_ A#: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PROGRAM ENROLLMENT INFORMATION

Do NOT complete this form if the Applicant Waiver section above has not been completed by the applicant.

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

College/Institution Name: \_\_\_\_\_

Department Chair/Director Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Select the program applicant was enrolled in:

- |  |   |
|--|---|
| <input type="checkbox"/> Dental Assisting              | <input type="checkbox"/> Veterinary Technician          |
| <input type="checkbox"/> Traditional RN (ADN/BSN)      | <input type="checkbox"/> Medical Lab Technology         |
| <input type="checkbox"/> LVN/Paramedic-RN              | <input type="checkbox"/> Occupational Therapy Assistant |
| <input type="checkbox"/> LVN-BSN                       | <input type="checkbox"/> Physical Therapist Assistant   |
| <input type="checkbox"/> Vocational Nursing (VNE)      | <input type="checkbox"/> Radiological Technologist      |
| <input type="checkbox"/> Surgical Technologist         | <input type="checkbox"/> Respiratory Therapist          |
| <input type="checkbox"/> Diagnostic Medical Sonography | <input type="checkbox"/> Other: _____                   |

First Semester Attended: \_\_\_\_\_ Last Semester Attended: \_\_\_\_\_

1. Identify the reason for the students withdraw from the program academic disciplinary
2. Is the student eligible to continue in the program? yes no
3. Is the student eligible to reapply for admission to the program? yes no

Director/Department Chair Signature \_\_\_\_\_

Date \_\_\_\_\_

### Respiratory Care Admissions Administrative Use ONLY

APPROVED  DENIED

By: \_\_\_\_\_  
 Michael White, Department Chair