



Application for Graduate Study

College of Health Professions

Temple University

PLEASE ENCLOSE THE \$65.00 APPLICATION FEE PAYABLE TO TEMPLE UNIVERSITY

Mail to:
 Ms. Sarah Carroll
 DPT Program Admissions
 Department of Physical Therapy
 Temple University
 3307 North Broad Street
 Philadelphia, PA 19140

Please type or print legibly using dark blue or black ink.

1. Social Security Number _____ - _____ - _____ 2. Country of Citizenship _____

3. Full Legal Name _____
LAST/SURNAME/FAMILY NAME FIRST MI

4. Prior Name(s) Used (if any) _____

5. Date of Birth* _____ 6. Gender* Male Female 7. Ethnicity* African American Asian or Pacific Islander
MONTH/DAY/YEAR Hispanic/Latino Native American
 White Other

**Provision of this information is voluntary and will not affect consideration of application. Responses are solely for assessing compliance with civil rights laws.*

8. Permanent Home Address _____
NUMBER & STREET CITY

COUNTY STATE ZIP CODE

COUNTRY HOME TELEPHONE NUMBER

9. Current Mailing Address (if different from permanent address)

NUMBER & STREET CITY

COUNTY STATE ZIP CODE

COUNTRY HOME TELEPHONE NUMBER CELL PHONE NUMBER E-MAIL

10. Semester Applying for: Fall Year _____ 11. Program/Curriculum Doctor of Physical Therapy

12. Statement of Residence (Required of ALL Applicants)

Country of Citizenship _____ Native Language _____

U.S. Permanent Resident? Yes No Type of U.S. Visa (if alien): F1 J1 Other _____

U.S. State of Legal Residence _____ County _____

If you claim Pennsylvania residency, will you have resided in Pennsylvania for 12 consecutive months preceding entry into Temple? Yes No

If you claim Pennsylvania residency, have you been a student at any time during the past 12 months? Yes No

If yes, what school, college or university did you attend and where? _____

If currently in military service, are you assigned to active duty at a military installation in Pennsylvania? Yes No

If you are related to a military person assigned to active duty in Pennsylvania, indicate whether you are a: Spouse Dependent

If you are a veteran and would like to receive information on support services for veterans, please check this box

I am now, and have been since, _____ a legal resident of the state of _____
MONTH/YEAR