

**NORTHWEST FLORIDA STATE COLLEGE  
ALLIED HEALTH PROGRAMS  
APPLICATION FOR ADMISSION**

**APPLICATION MUST BE SUBMITTED BY PROGRAM APPLICATION DEADLINE**

PLEASE TYPE OR PRINT LEGIBLY

NAME \_\_\_\_\_ OWC ID NO. \_\_\_\_\_  
LAST FIRST MI MAIDEN

MAILING ADDRESS \_\_\_\_\_  
Street City State Zip

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

CURRENT PLACE OF EMPLOYMENT: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
NAME RELATIONSHIP PHONE NO.

I am applying for: **(Check all programs you are applying for – submit only 1 application)**

\_\_\_\_ EMT  
 \_\_\_\_ Paramedic

Are you: \_\_\_\_ A beginning student \_\_\_\_ A transfer student

If transfer student: Program area previously enrolled in \_\_\_\_\_ Dates of attendance \_\_\_\_\_

Name/location of School \_\_\_\_\_

Reason for leaving program \_\_\_\_\_

Do you currently have a CPR card? No \_\_\_\_ Yes \_\_\_\_ (Attach copy of card, if "yes")

Are you currently enrolled at another institution? No \_\_\_\_ Yes \_\_\_\_ (If yes, where? \_\_\_\_\_)

**PREVIOUS EDUCATIONAL BACKGROUND**

Name of School	City/State	Dates of Attendance	Diploma/Certif/ Degree Received	Major Area of Study
High School or GED				
College or University				

**LICENSE CERTIFICATION** – Complete this section if you are currently licensed or hold certification in applicable area

Certification or License	Issued by Which State Agency	License Number	Date Issued	Expiration Date

The following items must be sent to the OWC Office of Enrollment Services no later than the application deadline.

- \_\_\_\_ OWC admissions application and residency documents
- \_\_\_\_ Official college transcripts from all institutions previously attended, including AP and CLEP credits
- \_\_\_\_ Official high school transcript or GED certificate or score report, as applicable
- \_\_\_\_ Verification of all testing (FCPT, TABE, HPI) and completion of all college prep courses as applicable to the program.
- \_\_\_\_ Verification of OWC orientation completion – complete online at [www.owc.edu/orientation](http://www.owc.edu/orientation)
- \_\_\_\_ If you are transferring from another program, letter from former program director verifying good standing

I attest that the information provided on this application is true and accurate. I understand that any falsification of information invalidates my application. I understand that I am responsible for submitting all of the above information and any omission may result in denial of my application.

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

Submit application to NWF State College Emergency Services Department by mail (must be postmarked by application deadline), fax, or in person to: NWF State College Emergency Services Department, Building E, 100 College Boulevard, Niceville FL 32578 FAX: (850) 729-5263

**HEALTH RELATED WORK AND/OR VOLUNTEER EXPERIENCE  
RELEASE OF INFORMATION CONSENT  
COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING OR PARAMEDIC**

**Please complete if you have been previously enrolled in a health related program at another college/university OR if you have been employed or performed volunteer work in a health related area.**

APPLICANT'S NAME (Please print) \_\_\_\_\_

I, hereby, authorize the release of information related to my previous performance as a student in other health-related programs and/or employment records from the employers listed below to the Emergency Services Department at NWF State College.

Signature \_\_\_\_\_ DATE \_\_\_\_\_

Employer \_\_\_\_\_ Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Title \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_ Full Time \_\_\_\_\_ Part time \_\_\_\_\_ Job Title \_\_\_\_\_

Job Duties \_\_\_\_\_  
\_\_\_\_\_

Signature of Employer/Supervisor \_\_\_\_\_ Date \_\_\_\_\_

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Employer \_\_\_\_\_ Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Title \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_ Full Time \_\_\_\_\_ Part time \_\_\_\_\_ Job Title \_\_\_\_\_

Job Duties \_\_\_\_\_  
\_\_\_\_\_

Signature of Employer/Supervisor \_\_\_\_\_ Date \_\_\_\_\_

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Employer \_\_\_\_\_ Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Title \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_ Full Time \_\_\_\_\_ Part time \_\_\_\_\_ Job Title \_\_\_\_\_

Job Duties \_\_\_\_\_  
\_\_\_\_\_

Signature of Employer/Supervisor \_\_\_\_\_ Date \_\_\_\_\_

(Attach duplicate forms as needed)