NEW YORK MEDICAL COLLEGE

A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

School of Health Sciences and Practice

and INSTITUTE OF PUBLIC HEALTH

APPLICATION

Post-Graduate Certificate in Pediatric Dysphagia

The Post-Graduate Certificate in Pediatric Dysphagia is designed for those that hold a license and certification in Speech Language Pathology. We will accept students on a rolling basis for Fall 2020 and will close the program once it reaches capacity. You must submit all items for your application to be considered complete. Please email the following to: shsp_admissions@nymc.edu.

- Completed Application
- Application fee ($75) paid online at www.nymc.edu/pedsdysfee.
- Copy of state licensure and professional certification
- Resumé or curriculum vitae

_____

Prefix Last First Middle

DATE OF BIRTH ____ /____ /____ PLACE OF BIRTH _____
(month) (day) (year) State/Country

MALE / FEMALE _____ ANY NAMES PREVIOUSLY USED _____

HOME PHONE (_____) _____-_____ CELL PHONE (_____)_____-_____ EMAIL _____

CURRENT ADDRESS _____
Number and Street

_____
City County State Zip Code

PERMANENT ADDRESS _____
Number and Street

_____
City County State Zip Code

Have you previously applied for admission to New York Medical College? _____

If Yes, semester/year/program _____

How did you hear about the Post-Graduate Certificate in Pediatric Dysphagia at New York Medical College?

_____

PERSONAL STATEMENT:
Why are you interested in pediatric dysphagia? (250 words maximum)

EDUCATIONAL BACKGROUND:

Please list all post-secondary schools attended. List the most recent school first.

Post-secondary Schools	Location	Dates Attended (Month/Year)	Major	Degree	Date or expected date of degree

WORK EXPERIENCE

Please list the most recent experience first. Add additional sheets, if necessary. Be sure to include any speech-language pathology experience. Your attached résumé does not substitute for completion of this section.

Employer Name & Location	Dates of Employment	Position	Full-time-paid , Part-time paid or Volunteer

ASHA Certification No: _____ State License No: _____ Clinical Fellow: __

CITIZENSHIP:

Are you a citizen of the United States?_____If citizen of another country, name of country _____

If Permanent Resident, Alien Registration Number_____ Year of immigration to the United States _____

Permanent Resident of another country (name) _____

If you are not a U.S. citizen or U.S. resident alien, are you:

Currently in the United States as an F-1 student at another University: (Name of University): _____

Degree Program: _____ Expected date of completion: _____ End date on your I-20 _____
(month / day / year)

Currently in the United States in another visa category: Visa Status:_____Expiration date: _____

I hereby certify that the information given above and in any attached documents is complete and accurate. I acknowledge that all materials submitted become the property of the College and cannot be returned or photocopied for me.

SIGNATURE_____DATE_____

The School of Health Sciences and Practice at New York Medical College admits qualified students regardless of race, color, national or ethnic origin, creed, sex, age, or disability to all of its programs and activities.