



# Lincoln Memorial University- DeBusk College of Osteopathic Medicine

## Supplemental Application

*For 2012 admissions cycle*

**Date of Application:** \_\_\_\_\_

**LMU ID #:** \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle Preferred Name

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_

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

\_\_\_\_\_ Telephone \_\_\_\_\_ Email \_\_\_\_\_  
County (Area Code) Circle one : CELL or HOME

Are you a U.S. Citizen?  Yes  No

If you checked "No," what is your visa status?  Permanent Resident  
 Temporary: please specify \_\_\_\_\_  
 I currently do not have a valid U.S. visa.

What is your racial identification?

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Hispanic or Latino                        |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> White (non-Hispanic)                      |

Medical College Admissions Test (MCAT)

<u>Dates Taken</u>	<u>Individual Scores</u> <small>(verbal/physical/writing/biological)</small>	<u>Total Score</u>

List any relatives who have attended Lincoln Memorial University

Name	Relationship	Class	Name	Relationship	Class

How do you plan to finance your osteopathic medical education? (Check all that apply)

- Loans  Personal/family funds  Military scholarship  Other: Please specify \_\_\_\_\_

What is the population of your hometown?  1,000,001 or more  10,001 to 50,000  
 500,001 to 1,000,000  5,001 to 10,000  
 100,001 to 500,000  2,500 to 5,000  
 50,001 to 100,000  Fewer than 2,500

Are there any health-care professionals in your family?  yes  no

What is his/her family relationship to you?  Parent  Sibling  Aunt/Uncle  Grandparent  Other

His/her occupation:  D.O.  Physician Assistant  Physical therapist  
 M.D.  Nurse  Mental-health counselor  
 Dentist  Medical technician  Other

Specialization: \_\_\_\_\_

What is his/her family relationship to you?  Parent  Sibling  Aunt/Uncle  Grandparent  Other

His/her occupation:  D.O.  Physician Assistant  Physical therapist  
 M.D.  Nurse  Mental-health counselor  
 Dentist  Medical technician  Other

Specialization: \_\_\_\_\_

What is his/her family relationship to you?  Parent  Sibling  Aunt/Uncle  Grandparent  Other

His/her occupation:  D.O.  Physician Assistant  Physical therapist  
 M.D.  Nurse  Mental-health counselor  
 Dentist  Medical technician  Other

Specialization: \_\_\_\_\_

**Please describe your professional experiences.**

Job title: \_\_\_\_\_ Years employed? \_\_\_\_\_

Field of work:  Health-care related  Research related  
 Social-services related  Business related  
 Education related  Military  
 Legal/Law enforcement  Other

Job title: \_\_\_\_\_ Years employed? \_\_\_\_\_

Field of work:  Health-care related  Research related  
 Social-services related  Business related  
 Education related  Military  
 Legal/Law enforcement  Other

Job title: \_\_\_\_\_

Years employed? \_\_\_\_\_

- Field of work:
- |  |   |
|--|---|
| <input type="checkbox"/> Health-care related     | <input type="checkbox"/> Research related |
| <input type="checkbox"/> Social-services related | <input type="checkbox"/> Business related |
| <input type="checkbox"/> Education related       | <input type="checkbox"/> Military         |
| <input type="checkbox"/> Legal/Law enforcement   | <input type="checkbox"/> Other            |

**Please describe significant volunteer experiences.**

Organization: \_\_\_\_\_

Years involved? \_\_\_\_\_

- Field of volunteering:
- |  |   |
|--|---|
| <input type="checkbox"/> Health-care related     | <input type="checkbox"/> Community building |
| <input type="checkbox"/> Social-services related | <input type="checkbox"/> Arts related       |
| <input type="checkbox"/> Education related       | <input type="checkbox"/> Other              |

Organization: \_\_\_\_\_

Years involved? \_\_\_\_\_

- Field of volunteering:
- |  |   |
|--|---|
| <input type="checkbox"/> Health-care related     | <input type="checkbox"/> Community building |
| <input type="checkbox"/> Social-services related | <input type="checkbox"/> Arts related       |
| <input type="checkbox"/> Education related       | <input type="checkbox"/> Other              |

Organization: \_\_\_\_\_

Years involved? \_\_\_\_\_

- Field of volunteering:
- |  |   |
|--|---|
| <input type="checkbox"/> Health-care related     | <input type="checkbox"/> Community building |
| <input type="checkbox"/> Social-services related | <input type="checkbox"/> Arts related       |
| <input type="checkbox"/> Education related       | <input type="checkbox"/> Other              |

Have you ever attended a medical school as a candidate for a D.O. or M.D. degree?  Yes  No

If "Yes," please specify program \_\_\_\_\_

How did you hear about Lincoln Memorial University - DeBusk College of Osteopathic Medicine?

- |   |                                   |                                      |  |
|---|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Pre-professional advisor | <input type="checkbox"/> D.O.     | <input type="checkbox"/> M.D.        | <input type="checkbox"/> Osteopathic Medical College |
| <input type="checkbox"/> Media (TV, Radio, Print) | <input type="checkbox"/> AOA      | <input type="checkbox"/> AACOM       | <input type="checkbox"/> Professional Organization   |
| <input type="checkbox"/> Recruitment Mailing      | <input type="checkbox"/> Internet | <input type="checkbox"/> Other _____ |  |

## ESSAYS

Please write and **ATTACH** two short essays addressing the following questions:

- 1) What personal qualities do you possess that will help you become a successful osteopathic physician?
- 2) In your own life, what experiences and/or people have inspired you to become an osteopathic physician?

## LETTERS OF REFERENCE

Please submit the following:

\_\_\_\_ Either a letter from your school's pre-professional committee **or** two letters from science professors

- and -

\_\_\_\_ A letter of reference from a physician

All letters of recommendation should be received prior to your interview.

Please list all individuals who will write letters:

1. Name \_\_\_\_\_  
Title or Rank \_\_\_\_\_  
Telephone \_\_\_\_\_ Date Requested \_\_\_\_\_
2. Name \_\_\_\_\_  
Title or Rank \_\_\_\_\_  
Telephone \_\_\_\_\_ Date Requested \_\_\_\_\_
3. Name \_\_\_\_\_  
Title or Rank \_\_\_\_\_  
Telephone \_\_\_\_\_ Date Requested \_\_\_\_\_

NOTE: Under the Family Educational Privacy Rights Act, 20 U.S.C. 1232(g), you may, but are not required to, waive your right of access to confidential references given for any of the purposes listed on this form. If you waive your right to access, the waiver remains valid indefinitely. Check the appropriate box below:

- I waive my rights of access to references given by the person(s) named above.
- I do not waive my right of access to references given by the normal persons(s) named above.

**Statement of Past or  
Pending Disciplinary Action**

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been subject to revocation of a professional license or been censured, reprimanded or placed on probation for reasons relating to professional competence or conduct by a state licensing authority? If "Yes," please explain.

Yes     No

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Have you ever had disciplinary action taken against you by any professional society or professional association? If "Yes," please explain.

Yes     No

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Have you ever been treated for problems with alcohol or drugs? If "Yes," please explain.

Yes     No

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Are there any other factors (or special circumstances) that might limit your ability to complete the LMU-DCOM program or be certified for licensure? If "Yes," please explain.

Yes     No

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## CERTIFICATION

I certify that all information provided on this application is true and accurate, complete and correct to the best of my knowledge and belief, and is made in good faith. I know and understand that any and all items contained herein are subject to verification and I consent to the full release of all information concerning my capacity and fitness for the educational program by employers, educational institutions and other agencies. I agree that providing inaccurate or false information or that failure to comply with University policy may result in disciplinary action, including dismissal. Throughout my enrollment, I agree to comply with the rules and regulations in the Lincoln Memorial University-DeBusk College of Osteopathic Medicine student handbook (available at [www.lmunet.edu/dcom](http://www.lmunet.edu/dcom)). Finally, I authorize the people named on my LMU-DCOM Supplemental Application to provide an evaluation about my academic performance and/or nonacademic experience relative to my potential for becoming an effective osteopathic physician.

**Signature of Application** \_\_\_\_\_ **Date** \_\_\_\_\_

- I have enclosed a \$50.00 non-refundable application fee.**
- I qualified for an AACOMAS fee waiver and have enclosed a copy of the letter.**

*Please return to:* LMU-DCOM, Office of Admissions and Student Advancement, 6965 Cumberland Gap Parkway, Harrogate, TN 37752