

Xavier University Graduate Program in Health Care Mission Integration

PERSONAL INFORMATION

Name _____ Social Security Number _____

Other name(s) records may be listed under (maiden) _____ Citizenship _____

Current address _____ County _____

City _____ State _____ Zip _____

Phone number _____

Permanent address _____ County _____

City _____ State _____ Zip _____

Home telephone _____ Work telephone _____

E-mail address _____

ENROLLMENT INFORMATION

I am applying as a degree-seeking student for admission to:

GRADUATE PROGRAM IN HEALTH CARE MISSION INTEGRATION

As a part-time student

Beginning in Fall 20____

TEST SCORE INFORMATION

I have taken or plan to take the:

Miller Analogies Test date: _____

GRE date: _____

You must have taken the test within the past five years. Official scores must be sent directly from the testing agency to Xavier. (MAT school code 1965; GRE school code 1965).

ACADEMIC INFORMATION

List all colleges and/or universities attended (undergraduate and graduate) beginning with the most recent (attach additional sheet if necessary):

University/College name	Dates attended	Degree	Major/concentration

The information in the following section will not be used in making an admission decision. Your disclosure of this information is voluntary, but is valuable to the University for statistical, planning and administrative purposes.

Religion _____

Date of birth _____ Marital status _____ Gender _____

Ethnicity African-American White Hispanic
 Asian, Pacific Islander American Indian Other

Employer _____ Position _____ Full-time Part-time

How did you hear about Xavier’s Master of Arts in Health Care Mission Integration degree?

What is your experience in health care and/or ministry?

DISCIPLINARY AND CRIMINAL HISTORY

Have you been the subject of disciplinary or academic action and/or have you ever been convicted of a crime?*

Check the appropriate space(s) below.

I have not been the subject of disciplinary or academic action by any institution, professional organization, ethics or licensure board, or other credentialing body, and I have not been convicted of a crime (other than minor traffic violations). (If you check here, please skip to the signature line below).

If you answer yes to any of the following statements, please attach a letter giving details.

- I have been convicted of a crime, misdemeanor or felony (other than a minor traffic violation) or been sentenced to a correctional or penal institution.
- I have had academic or disciplinary action taken against me at an educational institution.

* Applicants should note that because of the high ethical standards to which health care administrators are held, the failure to disclose an act or event is often more significant and leads to more serious consequences than the act or event itself. Failure to provide truthful and complete answers or failure to inform the program of any changes to your answers may result in revocation of admission to the program or disciplinary action by the program.

I certify that the information contained in this application is complete and accurate. I understand that incorrect or withheld information can be the cause for the refusal of admission, cancellation of admission or cancellation of credits.

Applicant’s signature _____ Date _____

Submit this application and a \$35 nonrefundable application fee to: Department of Health Services Administration, Xavier University, 3800 Victory Parkway, Cincinnati, Ohio 45207-7331. Send recommendation forms to two evaluators whose previous contact with you enables them to assess your ability to pursue the Master of Arts in Health Care Mission Integration. For more information call 513-745-3687 or 513-745-2021 or visit the web site at www.xavier.edu/mhsa or www.xavier.edu/theology-ma.

Recommendation form

INSTRUCTIONS TO THE APPLICANT

Complete the section below and ask your recommender to return this to us directly. They should seal the envelope, then sign across the back. Select evaluators whose previous contact with you enables them to assess your ability to pursue graduate studies, who are familiar with your professional work and/or are acquainted with your academic record.

PERSONAL INFORMATION

Applicant's name _____

Current address _____ County _____

City _____ State _____ Zip _____

Phone number _____ E-mail _____

I AM APPLYING FOR ADMISSION TO:

- H.C.M.I. program only
 - As a part-time student
- Beginning in Fall 20____

The Family Education Rights and Privacy Act of 1974 permits you to review letters of recommendation. You may waive this right in order to allow your recommender to submit a confidential recommendation on your behalf. You must complete the following statement indicating whether you waive or maintain this right. Please select one by placing a check in the box and signing below.

- I hereby waive my right to this recommendation.
- I hereby maintain my right to review this recommendation.

Applicant's signature _____ Date _____

INSTRUCTIONS TO THE EVALUATOR

Please give your candid evaluation of the applicant's potential for successful graduate study in health care mission integration by responding to the following questions. We strongly prefer that you complete the questions listed in this evaluation form. This form should be returned directly by you to the Xavier University department of health services administration in the envelope provided. You should seal the envelope, then sign across the back.

1. How long have you known the applicant? In what capacity?

_____ Dates: _____

2. What do you consider to be the applicant's strengths and accomplishments as they pertain to suitability for graduate study in health care mission integration?

3. What do you consider the applicant's major weaknesses as they pertain to suitability for graduate study in health care mission integration?

	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	DON'T KNOW
Analytical ability					
Justice awareness					
Research ability					
Writing skills					
Oral communication skills					
Listening skills					
Interpersonal skills					
Maturity					
Self-confidence					
Motivation					
Initiative					
Leadership potential					
Orientation to service					

4. Comment on the ratings you assigned above and the applicant's record, potential or personal qualities that may be helpful to the admissions committee. We are interested in any insight you can add that might not otherwise be apparent on the applicant's record. Please attach an additional sheet of paper if needed.

PLEASE CHECK ONE:

- I strongly recommend this applicant.
- I recommend this applicant, but with reservation.
- I recommend this applicant.
- I do not recommend this applicant.

Please print or type the information below, or if you prefer, attach your business card. If you attach a business card, you must sign and date the last line for authentication. Please mail the two-page form to the address in the lower left corner.

Name _____ Title _____

Institution (including department) _____ Daytime phone number: _____

Address: _____

Signature _____ Date: _____



**Department of Health Services
Administration**
3800 Victory Parkway
Cincinnati, Ohio 45207-7331

FOR MORE INFORMATION

PHONE	E-MAIL
513-745-3687	xumhsa@xavier.edu
513-745-2021	FAX
TOLL-FREE	513 745-4301
800-344-4698	
EXT. 3687	

Recommendation form

INSTRUCTIONS TO THE APPLICANT

Complete the section below and ask your recommender to return this to us directly. They should seal the envelope, then sign across the back. Select evaluators whose previous contact with you enables them to assess your ability to pursue graduate studies, who are familiar with your professional work and/or are acquainted with your academic record. They should be able to assess your ability to pursue the MA in Health Care Mission Integration.

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Phone number _____ E-mail _____

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TOLL-FREE	513 745-4301
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EXT. 3687	

Transcript request

Master of Arts in Health Care Mission Integration

Date _____

To the registrar: I am applying for admission to Xavier University's Master of Arts in Health Care Mission Integration.

Please mail one complete transcript of my record to the address below:

Last name _____ First _____ Middle _____

Social Security Number _____ Previous name (if applicable) _____

DATES ATTENDED

	Semester/Year	Degree
<input type="radio"/> Undergraduate	_____	_____
<input type="radio"/> Graduate	_____	_____
<input type="radio"/> Other	_____	_____

Student's signature _____

Address _____

Amount enclosed \$ _____

MAIL TO

Xavier University
Department of Health Services Administration
Attn.: Admission Coordinator
3800 Victory Parkway
Cincinnati, Ohio 45207-7331

NOTE: Feel free to make copies of this form. Send to the registrar at every college or university you have attended.



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Administration**
3800 Victory Parkway
Cincinnati, Ohio 45207-7331