ST. LUKE'S COLLEGE OF MEDICINE
William H. Quasha Memorial

APPLICATION FOR ADMISSION

SCHOOL YEAR_____

Photo
2" x 2"

NAME_____
(Please Print) LAST FIRST MIDDLE

Mailing Address_____ Tel. No._____

Permanent Address_____ Tel. No._____

_____ Zip Code_____ Mobile No._____

Date of Birth_____ Place of Birth_____ Gender_____ Citizenship_____

Civil Status_____ Religion_____ E-mail Add_____

Father_____ Occcupation_____ Phone_____

Mother_____ Occcupation_____ Phone_____

Guardian_____ Address_____ Phone_____

Elementary School_____ Year Graduated_____

High School_____ Year Graduated_____

College_____ Year Graduated_____

Pre-Med Course_____ Year Graduated_____

School Last Attended_____ School Year _____

Honors/Awards_____

Give a candid evaluation of yourself, your strengths and weaknesses. (Use additional sheet if necessary)

_____

_____

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_____

What is the value of medical education to you? (Use additional sheet if necessary)

_____

_____

_____

How did you know of St. Luke's College of Medicine - William H. Quasha Memorial?

_____

What made you consider St. Luke's College of Medicine? Please rank according to importance.
(1 = most important; 6 = least important)

☐ Curriculum ☐ Scholarship Opportunity ☐ Facilities

☐ Reputation ☐ Career Opportunities ☐ Others _____

Have you applied in other medical school(s)?

[ ] No [ ] Yes_____ _____
School Status of Application

Have you ever been enrolled in other medical school(s)?

[ ] No [ ] Yes_____ _____
School Date/School Year

IF FOREIGN APPLICANT: ACR No. _____ VISA STATUS _____

IMPORTANT: The application for admission does not mean automatic acceptance to the College of Medicine

I certify to the veracity of the above information, any evidence of fraud in the credentials/documents submitted will automatically nullify my enrollment in the College of Medicine.

I certify further that if accepted, I will abide by all the rules and regulations of the College and CHED.

OR No._____ _____
Signature of Applicant

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Website: stlukesmedcollege.edu.ph