

**Daytona State College / Palmer College of Chiropractic Florida Campus
APPLICATION FOR JOINT ADMISSIONS**

Complete all information and return this application to the Palmer College of Chiropractic, Florida Campus Admissions Department. Please type or print clearly.

| | | | |
|---|-----------------|----------|-------------------------------------|
| PERSONAL DATA | | | Social Security # _____ |
| Name | _____ | _____ | _____ |
| | First | Middle | Last |
| Other Name(s) | _____ | | |
| <small>Any names that may appear on supporting documents.</small> | | | |
| Current Mailing Address | _____ | | Phone _____ |
| | Number & Street | | |
| | _____ | _____ | _____ |
| | City | State | Zip |
| Permanent Mailing Address | _____ | | Phone _____ |
| | Number & Street | | |
| | _____ | _____ | _____ |
| | City | State | Zip |
| U.S. Citizen or Resident? | Yes _____ | No _____ | If no, country of citizenship _____ |

| | | | |
|--|---|-------------------------------|------------------------|
| ADMISSIONS DATA | | | |
| High School Name | _____ | | |
| High School Address | _____ | _____ | _____ |
| | Number & Street | City | State Postal Code |
| Graduation Date _____ | High School graduation by: Diploma _____ | Equivalency Certificate _____ | |
| Anticipated Term of Entry at Palmer College of Chiropractic's Florida Campus | _____ | | |
| | month/year | | |
| Other colleges attended prior to anticipated enrollment date at Palmer's Florida Campus | _____ | | |
| | _____ | | |
| | _____ | | |

| | |
|---|---------------------------------|
| Intended Daytona State College courses to be taken | Degree Program: _____ |
| | OR |
| | Course number _____ Title _____ |
| | Course number _____ Title _____ |
| | Course number _____ Title _____ |
| | Course number _____ Title _____ |
| Anticipated entry date at DSC | _____ |
| | month/year |

I authorize Daytona State College and Palmer College of Chiropractic, Florida Campus to release confidential education record information (including grade reports and/or transcripts) to each other.

I certify that the foregoing information is true and complete to the best of my knowledge and realize that failure to provide official transcripts and other required information may result in the cancellation of admission or registration.

Student Signature (Required) _____
Date

Palmer College of Chiropractic, Florida Campus _____
Authorized Signature Date

| | | |
|--------------------------|---|-------------------------------------|
| For DSC office use only: | Return document to: | For Florida Campus office use only: |
| Date Received | Palmer College of Chiropractic's Florida Campus | Term |
| Term Applied | Attn: Admissions | Fee Paid |
| | 4777 City Center Parkway | Status |
| | Port Orange, FL 32129 | |
| | Fax: (386) 763-2620 | |