

**State of Montana  
Professional Student Exchange Program  
Application for Certification**

**Name:** \_\_\_\_\_ **Social Security No:** \_\_\_\_\_  
(Last, First, Full Middle)

**Present Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
(Street, City, State, Zip Code)

**Permanent Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
(Street, City, State, Zip Code)

**Email Address:** \_\_\_\_\_ **Gender:** Male  Female

**Parental Information:**

**Father:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
(Name) (Street, City, State, Zip Code)

**Mother:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
(Name) (Street, City, State, Zip Code)

Name of Parent or Guardian claiming you as a dependent for income tax purposes: \_\_\_\_\_

**List of Colleges and Universities You Have Attended:**

Name of College/University	Dates Attended	Diploma/Degree
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Current Enrollment**

Name of College/University \_\_\_\_\_ Year:  Freshman  Sophomore  Junior  Senior  
Date you expect to complete all requirements for admission to professional school: \_\_\_\_\_  
(Month/Day/Year)

Are you currently enrolled in a professional program? Yes  No

If Yes, name of professional school: \_\_\_\_\_ Field of Study: \_\_\_\_\_

**Program(s) to which you are applying:  
(check all that apply)**

- WICHE
- WWAMI
- Minnesota Dental

**Field(s) of Study You Are Requesting Certification For:  
(check all that apply)**

- Dentistry
- Medicine
- Occupational Therapy
- Optometry
- Osteopathic Medicine
- Podiatry
- Veterinary Medicine

List of Schools to which you are applying in order of preference (Attach additional sheet if necessary):

- 1) \_\_\_\_\_ 4) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_

Where do you plan to practice upon completion of your professional program? \_\_\_\_\_

**I hereby certify that, to the best of my knowledge, the above information is true and complete without evasion or misrepresentation. I understand that if it is later found otherwise, it is sufficient cause to disqualify me from participation in these professional programs.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**For statistical purposes only:**

- Ethnicity:  African American  Native American  
 Asian American  White/Caucasian  
 Hispanic