



## Applicant Demographic Questionnaire

Please complete the following questionnaire and submit it with your completed short essay, proof of acceptance, and a copy of your transcript/grades

Applicant Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of school you attend(ed), or plan to attend in the upcoming school year: \_\_\_\_\_

Anticipated graduation date: \_\_\_\_\_

Are you currently a member of the American Association for Respiratory Care?  Yes  No