School of Health Sciences & Wellness
University of Wisconsin-Stevens Point

Health Care Administration &
Health Care Informatics Programs

Admission APPLICATION for HS 498~Experiential Learning

Name: ____
(Last) (Maiden) (First) (M.I.)

UWSP Student ID#: ____________________
Are you a US citizen? Yes ☐ No ☐
Are you a veteran? Yes ☐ No ☐

Term Applying for Experiential Credit: **FALL** ☐ **SPRING** ☐ **SUMMER** ☐

Present mailing address:
(Contact during the school year)

(Street address)

(City/Town) (State) (Zip)

(Home Phone Number with Area Code) (Cell Phone Number with Area Code)

(School E-mail Address)

Permanent mailing address:
(Contact during summer/breaks)

(Street address)

(City/Town) (State) (Zip)

(Home Phone Number with Area Code) (Cell Phone Number with Area Code)

(School E-mail Address)

Educational Information

School Name	Location (City/State)	Major/Area of Study	Dates Attended	Hours/Degrees Completed
College/University				
College/University				
College/University				

Courses

In Progress (current semester)			Planned (next semester)		
Course #	Course Title	Semester credits	Course #	Course Title	Semester Credits

University of Wisconsin~ Stevens Point
School of Health Care Professions
Health Care Administration & Health Care Informatics Programs

Work, Professional & Volunteer Experience

Name of Institution, City/State/Phone , Name of Supervisor	Dates (To/From)	Duties & Responsibilities

Reference Information

List ONE person we may expect to act as positive, personal character reference on your behalf. It is NOT expected this person will provide a letter of recommendation for you, rather, they can be contacted by the Experiential Learning Supervisor, or Community Agency Partner considering offering you a learning opportunity, to vouch for your character. Please include the requested contact information – **the Email address is required**.

Name & Title	Telephone Number	Email Address

Areas of Interest

(Check all that apply)

Aging/Epidemiology
Marketing
Survey
Data Analytics/Information
Technology Culture Change

Safety/Quality
Strategic/Operational Planning
Health Care Finance
Scheduling/Clerical/Admissions/Discharge/Billing

Training/Development
Personnel/ HR

General Exposure		Care Transitions	
Clinic	Hospital	LTC	Home Care

Statement of Intent

I authorize the Experiential Learning Supervisor to utilize and disseminate the information from this application (including criminal background check information, transcripts, references, etc.) to potential Community Partners for review in determining eligibility and suitability for this educational opportunity. I have read the student policies and guidelines, understand their content, and agree to abide by them if accepted into the Experiential Learning Option. I attest that the information in this application and the attachments are true and correct, and not a misrepresentation of myself.

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(Your Signature & Date)