

College of Public Health and Health Professions

101 S Newell Drive
University of Florida
Gainesville, FL

REHABILITATION COUNSELING STUDENT INFORMATION FORM

Date Form Completed: _____

Term you wish to enroll: _____

1. Name: _____
(Last) (First) (Middle)

2. UFID Number (if known): _____ Date of birth: _____

3. Address: _____
(Number and Street) (City) (State) (ZIP Code)

4. Phone: _____ Email Address: _____
(Area Code)

5. In Case of Emergency Contact: _____
(Name) (Relationship)

Address: _____
(Number and Street) (City) (State) (ZIP Code)

Phone: _____
(Area Code)

6. Employment

Employer	Address	Type of Work	Part/Full Time	Dates
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7. Armed Services

Branch	Highest Rank	Type of Duty	Dates
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8. Have you made formal application to the Office of Admissions of the University of Florida? _____
If yes, date of application _____
Are you currently enrolled at the University of Florida? _____

9. Test Scores

Test	Score				Test Date
GRE	V:	Q:	AW:	SUBJ:	/
GMAT	V:	Q:	TOTAL:		/

GPA for last 2 years of undergraduate study: _____

10. What factors or individuals have influenced you to select the University of Florida for study in a health career? (If additional space is needed, please attach your comments)

11. In your own words, (1) explain the reason(s) for your specific interest in this health career, (2) what experience, if any, you have had with this work, (3) what contacts you have had with persons working in the field of your major interest, and (4) what you feel you personally have to offer in this field. Please limit your essay to the space provided below.

I certify that the information given in this application is accurate and complete to the best of my knowledge. I understand that providing any untrue or misleading information in connection with my application for admission may result in the revocation of my admission to the University of Florida or revocation of any degrees awarded me by the University of Florida.

Signature: _____