Jacksonville University NROTC Preparatory Program Application

Personal Information

Name (Last, First, Middle)

Phone

Current Mailing Address

Name of Parent/Guardian

Address of Parent/Guardian

Place of Birth

Date of Birth

Are you a US Citizen? YES NO If Naturalized, give date, place, court of jurisdiction, and certificate number.

Gender

Male Female

What is your race? Mark one or more of the categories belo to indicate how you identify your race.

American Indian/Alaskan Native

Asian

African American/Black

Native Hawaiian/Other Pacific Islander

Caucasian

Korean	Other Asian Descent	US/Canadian Indian Tribes
Latin American w/ Hispanic Descent	Other Hispanic Descent	
Melanesian	Other Pacific Island Descent	Other
Mexican	Polynesian	None
Micronesian	Puerto Rican	

Intended Major or Area of Study (Tier 1 or Tier 2 only)

Parent/Legal Guardian

Status (Active/Retired)

Commissioning Source

READ CAREFULLY: Identify only those activities in which you engaged durin6.0063D W* n BT Tf 20.88 305.57 Td [(R)-8.003 (E)5 (q 511.9 47)-6.006 ()5b(n)7.988 (6.0063C /TT17g003

9	10	11	12
9	10	11	12
9	10	11	12
9	10	11	12

JV/Club

9	10	11	12
9	10	11	12
9	10	11	12
9	10	11	12

Volunteering

Grade	Volunteer Work Remarks
Other	
Total Volunteer Hours Per Year	

Answer the following questions. If you answer 'Yes' provide explanations on an additional shee Yes

4. Are you currently awaiting trail or sentence, on probation, under suspended sentence, or under any other type of military or civilian restrai result of violation of law or regulation?

5. Have you ever been known by any other name or names other than that used in this application? (If 'Yes', explain in affidavit form and su

Date

Date

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Medical History

Height	Weight	Date of Last Sports Physical / Private Sector Phys

Answer the following questions. If you answer 'Yes' provide explanations in block 41

	Yes	No
1. Eye trouble (to include vision loss, cataract, glaucoma, keratoconus, corneal ectasia, retinal detachment)?		
2. Surgery to improve vision (PRK, LASIK, LASEC, RK, intraocular lens implant, cross linking)?		
3. Color vision deficiency?		
4. Ear trouble (to include perforated ear drum, tubes in ears, or other ENT surgery)?		
5. Loss of balance or vertigo?		
6. Hearing loss or use of a hearing aid?		
7. Nose, throat, or sinus trouble (to include sinusitis, abscess, surgery on nose, sinuses or throat)?		
8. Orthodontic treatment? (if "yes", include completion or projected date of completion in block 41)		
9a. Tooth or gum trouble (excluding cavities)?		
9b. Date of last dental exam:	[redacted]	
10. Breathing trouble (to include asthma, wheezing, shortness of breath, chronic cough, use of inhaler, collapsed lung)?		
11. Cardiac trouble (to include chest pain, palpitations, heart valve problems, surgery, high or low blood pressure)?		
12. Gastrointestinal trouble (to include celiac disease, irritable bowel syndrome, ulcer, reflux, esophagitis, gallstones, hernia, hepatitis)?		
13. Inflammatory bowel disease (to include Ulcerative colitis or Crohn's disease)?		
14a. Gynecologic trouble (including endometriosis, polycystic ovarian disease, abnormal pap smear)? (females only)		
14b. Date of last menstrual period (females only):	[redacted]	
14c. Date of Last PAP smear (females only):		
15.Testicular or prostate trouble? (males only)		
16. Orthopedic problems of the back or neck?		
17. Orthopedic problems of the upper extremities (fracture, dislocation, sprain, surgery)?		
18. Orthopedic problems of the lower extremities (fracture, dislocation, sprain, surgery)?		
19. Vascular trouble (Raynaud's disease, blood clot or deep venous thrombosis, high blood pressure)?		
20. Skin trouble (to include psoriasis, eczema, atopic dermatitis, severe acne)?		
21. Prescribed systemic retinoid medications (i.e.: Accutane)? (List date completed or projected completion date in block 41.		
22. Blood disorders (anemia, thrombocytopenia, bleeding disorders, disorder of the spleen)?		
23. Allergic reaction to food, medications, insects?		
24. A positive PPD or been treated for tuberculosis?		
25. Car, train, sea, or air sickness that required prescription medication or avoidance of travel?		
26. Endocrine disorders (including diabetes, thyroid, osteoporosis)?		

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Medical History (Continued) Yes No

27. Head injury, memory loss, amnesia?

30. Sleeping trouble (narcolepsy, sleepwalking, chronic insomnia, sleep apnea)?

34. Evaluation or treatment for attention deficit hyperactivity disorder, attention deficit disorder, or learning disability?

35. Tumor or cancer?

36. Cold or heat injury?

37. Rhabdomyolysis?

38. Have you been C Q ficit disordng disability?

40. Have you EVER been rejected or discharged for military service for any reason?

Medical Comments

41. Explain all "Yes" answers to questions 1-40 above. Begin with the Item Number. Describe answer(s): provide date(s) of problem(s) /conditi provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evalua treatment); and describe your current medical status (ongoing/resolved). Attach additional sheet(s) if necessary and sign and date each additio Obtain and attach copies of applicable medical evaluation and treatment records if requested.

I certify that all medical information provided by me is complete and correct to the best of my knowledge.
Applicant Signature Date