Premedical/Predental/Preveterinary
REGISTRATION FORM
Preprofessional Advising Office

Name__________________________________________ BUID _______________________

Local Address ________________________________________________________________
____________________________________________________________________________

Local Phone________________________ BU E-mail_____________________________

Home Address _______________________________________________________________
____________________________________________________________________________

Home Phone________________________

College/School________________________ Year of Graduation____________________

Major ____________ Minor ____________ Faculty Advisor __________________________

Other Colleges Attended________________________________________________________

School you are interested in:     ___Medical     ___Dental     ___Veterinary     ___Optometry

     ___Physician Assistant     ___Other (specify)_______________________________

Expected year of professional school entrance _______________

Do you wish to identify yourself as a member of any of the following groups?     ___yes     ___no
If so, which?

___African American     ___Mexican American
___American Indian     ___Puerto Rican
___Alaskan Native/Hawaiian Native     ___Other Black___________________________
___Asian/Pacific Islander     ___Other Hispanic/Latino_________________________
___Caucasian/White     ___Other (non-Black or non-Hispanic/Latino)____________

__________________________________________     Date ___________