



APPLICATION FORM FOR NON-MATRICULATED APPLICANTS

**SUNY DOWNSTATE MEDICAL CENTER
SCHOOL OF PUBLIC HEALTH**

450 Clarkson Avenue, MSC 43B, Brooklyn, NY 11203

Phone (718) 270-1065 | Fax: (718) 270-2533

E-mail: PublicHealth@downstate.edu



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DOWNSTATE
Medical Center

School of Public Health

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Instructions for Non-Matriculated Applicants

Individuals who wish to be considered as non-matriculated students must meet the following criteria:

1. Completion of an accredited Bachelor's degree program or higher from a CHEA regionally accredited college and/or university.
2. Completion of the non-matriculated form.
3. Submission of an official transcript of all degrees completed.
4. A personal interview with a designated member of the faculty.

Individuals accepted as non-matriculated students are limited to specific courses in each department (see list below). Students must achieve a GPA of 3.0 or higher to be considered for subsequent admission as a matriculated student.

Courses Available for Non-matriculated Students:

Approved non-matriculated students may take any four (4) of the five (5) core MPH courses (listed below). No more than twelve (12) credits in a non-matriculated status are allowed.

MPH Core Courses:

- Principles of Biostatistics
- Principles of Epidemiology
- Health Behavior and Risk Reduction
- Principles of Environmental Health
- Introduction to Health Policy and Management

* Non-matriculated students wishing to take other courses must secure the permission of the chair of that particular department.

Non-matriculate Application Process:

If the non-matriculated student subsequently wishes to apply to the program as a matriculated student, then s/he must complete the formal application process, and be accepted based on the criteria. Credits from the courses taken as a non-matriculated student will apply to the student's MPH course credits.

Note that an application to become a matriculated student does not guarantee admission.

The School determines which courses are open to non-matriculated students as well the number of students allowed in each course.

Your application will not be processed if you are not able to provide the supporting documents listed below:

A completed application file includes:

- ❑ Completed and signed application form for Non-Matriculated students
- ❑ One official transcript(s) for all colleges/universities attended
- ❑ Proof of NYS Residency. Any two (2) documents listed below are sufficient to prove NYS residency:
 - Voter Registration Card
 - Utility Bill (eg: Electric, Phone, Gas, etc...)
 - NYS Tax Return
 - Alien Registration Card
 - NYS Driver's License
 - Lease
- ❑ Completed Health Assessment Form
- ❑ Health Clearance form obtained from the Student Health Services department

A complete application packet should be mailed to:
SUNY Downstate Medical Center
School of Public Health Office for Enrollment and Student Affairs
450 Clarkson Avenue, MSC 43B
Brooklyn, NY 11203



IMPORTANT INFORMATION

- Non-Matriculated students are NOT eligible for Financial Aid.
- Non-Matriculated students are NOT guaranteed matriculation to the School of Public Health. They must apply and meet all established program admission requirements.



TRANSCRIPT GUIDELINES

One official transcript, i.e. documents with the registrar's/ university school seal sent in the University's sealed envelope, must be received from each post-secondary (after high school) academic institution attended regardless of length of enrollment or credit granted. This includes, but is not limited to, summer classes, study abroad courses, medical school records, post baccalaureate courses and coursework towards advanced degrees. Only applications with official transcripts on file will be reviewed for an admission decision.



***Applicants who require additional evaluation, i.e. applicants who have completed more than one year of college level course work outside the USA, must request a course-by-course evaluation by an agency accredited by the NATIONAL ASSOCIATION OF CREDENTIAL EVALUATION SERVICES (NACES). A list of accredited course evaluation agencies can be found on NACES' website www.naces.eorg.*



Non-Matriculated Application Form

I am applying as a Non-Matriculated Student for admission for: Summer Fall Spring Year _____

IDENTIFICATION INFORMATION

(LAST NAME) (FIRST NAME) (MIDDLE INITIAL) (JR, III, ETC.)

If you have worked or have educational records under a different name, please give former name(s)

Date of Birth _____ Sex: Female Male
Month/Date/Year

Mailing Address _____

(NUMBER AND STREET) (APT. #)

(CITY) (STATE) (ZIP CODE) (COUNTRY, If other than US)

Home Telephone _____ Business Telephone _____ Cell Phone _____

E-mail address _____

****Must Complete****

How often do you check your e-mail? _____

Permanent Address (if different from above)

(NUMBER AND STREET)

(CITY) (STATE) (ZIP CODE) (COUNTRY, If other than US)

CITIZENSHIP/RESIDENCY INFORMATION (Priority will be given to U.S. citizens or Permanent Residents)

Place of Birth: _____

Current Status: U.S. Citizen Permanent Resident (provide copy of card)
 Temporary visa holder, specify visa category (F-1, H-1, etc.) _____ (attach a copy of immigration document)

PLEASE NOTE: If you are a permanent resident or temporary visa holder, a copy of your alien registration card or visa must be submitted with your application.

Are you a New York State resident (for tuition purposes)? Yes No

The definition of a New York State resident for tuition purposes appears in the Office of Admissions section of the website http://sls.downstate.edu/admissions/application_instructions.html

If you wish to identify yourself as a member of an ethnic/racial group, please indicate:

- African-American, Non-Hispanic Caucasian Hispanic/Latino
 Asian Native American/Alaskan Native Native Hawaiian/Pacific Islander
 Other _____

EDUCATIONAL HISTORY

Beginning with the most recent, list in chronological order ALL undergraduate and graduate institutions attended, regardless of how long ago you attended. You must submit official transcripts for all institutions listed.

Applicants educated abroad must submit an educational credentials evaluation.

University/College	City/State	Dates of Attendance (Month/Year)	# of Credits Completed/ In Progress	Overall GPA	Field of Study (Major & Minor)	Degree & Date

- Test of English as a Foreign Language (TOEFL) Date taken/planned _____
 Internet-based exam score: _____ Computer-based exam score: _____ Paper-based exam: _____

EMPLOYMENT HISTORY

(List most recent position first)

Please Note: Curriculum Vitae may be attached to the application in lieu of completing this section.

Dates (from/to)	Employer	City State	Title

ADDITIONAL INFORMATION

Was there a period of 3 months or longer when you were not in school and/or employed? No Yes
If YES, please briefly describe your activities during that time on a separate sheet.

APPLICANT'S SIGNATURE

I have read and understand the Admissions Brochure instructions. I certify that the information submitted in this application and associated material is complete, accurate and correct to the best of my knowledge.

 Applicant Signature

 Date

FOR OFFICE USE ONLY

PROGRAM CHAIR/VICE DEAN SIGNATURE: _____ **DATE:** _____

APPLICATION APPROVED

APPLICATION REJECTED

COMMENTS:

Admission to SUNY Downstate Medical Center is based on the qualifications of the applicant. SUNY Downstate Medical Center does not discriminate on the basis of race, sex, color, creed, age, national origin, disability, sexual orientation, religion, marital status or status as a disabled veteran in the Vietnam era. Responses on this application to questions of race, sex, and date of birth are voluntary and are used for statistical purposes only.



Course Selection Form for Non-Matriculated Applicants

- This form is used to obtain approval from the Program Chair and/or the Vice Dean to register for classes as a Non-Matriculated student.
- This form must be completed in its entirety. Both, the student and the designated faculty member **must** sign this form.
- Upon obtaining approval to register for courses as a Non-Matriculated student, this form **must** be submitted to the Office of the Registrar.

PLEASE PRINT CLEARLY

(LAST NAME) (FIRST NAME) (MIDDLE INITIAL) (JR, III, ETC.)

If you have worked or have educational records under a different name, please give former name(s)

Mailing Address

(NUMBER AND STREET) (APT. #)

(CITY) (STATE) (ZIP CODE) (COUNTRY, If other than US)

Please indicate the semester/year in which you intend to take these courses:

Summer _____ Fall _____ Spring _____

COURSE #	CRN #	COURSE TITLE	# OF CREDITS

Applicant Signature

Date

FOR OFFICE USE ONLY

PROGRAM CHAIR/VICE DEAN SIGNATURE: _____ **DATE:** _____

COURSE SELECTION APPROVED

COURSE SELECTION REJECTED

COMMENTS:



Health Assessment Form for Non Matriculated Students

Completion of this entire form is required of every non-matriculated student coming to SUNY Downstate Medical Center. ***It must be submitted with your application.*** Please note that a recent Mantoux test and chest x-ray (if needed), as well as immunity to measles, mumps, and rubella are required by New York State Health Code.

Name: _____ SID: _____
 Address: _____
 Tel: _____ E-Mail: _____
 School: _____ DOB: ___/___/___
 Elective at SUNY: _____ Elective Dates: ___/___/___ to ___/___/___

To the Health Provider:

1. Does this student have any acute or chronic health problems? If yes, please explain: _____

2. Date of last physical exam (must be no more than 1 year prior to start of elective): ___/___/___

Result of exam: _____

3. PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA IS REQUIRED BY NEW YORK STATE LAW.

Two (2) Doses of live measles, mumps and rubella vaccines after the first birthday or immune titers satisfy this requirement

MMR vaccine:	___/___/___	___/___/___
	#1 date	#2 date
Measles Titer:	___	___/___/___
	POS NEG	Date
Mumps Titer:	___	___/___/___
	POS NEG	Date
Rubella Titer:	___	___/___/___
	POS NEG	Date

4. HISTORY OF VARICELLA?

YES NO OR TITER _____

IF NO HISTORY OF VARICELLA AND NEGATIVE TITER, TWO DOSES OF VARICELLA VACCINE ARE REQUIRED.

DATES: ___/___/___ ___/___/___
 dose 1 dose 2

5. TUBERCULIN TEST (if known negative, Mantoux test must be administered, or blood-based tuberculin test, within 6 months prior to elective)

Date: ___/___/___ Result: ___ mm induration Manufacturer & Lot # _____
 CHEST X-RAY Date: ___/___/___ Result: _____

(Required if mantoux or blood-based tuberculin test is positive):

6. A dose of adolescent/adult Tdap within the past 10 years: DATE: ___/___/___

I certify that the above statements are true.

Name of Health Care Provider: _____
 Signature of Health Care Provider: _____
 State and License #: _____
 Address: _____
 Telephone #: _____
 Date: ___/___/___

After your Non-Matriculated application has been approved by the department you must submit this form to the above address or fax #. Failure to do so will delay the processing of your application.