

Baptist Health College Little Rock

Office: (501) 202-7495, Fax: (501) 202-6015

Administrative Service Request Form

**SUBMIT TO STUDENT SERVICES IN OFFICE 1004:
REQUESTS WILL BE FILLED WITHIN FIVE (5) WORKING DAYS.**

1. Name: _____ Other Name: _____ Date: _____

SS#: _____ E-Mail: _____

Primary Telephone: _____

Secondary Telephone: _____

2. **BHCLR Program:**

- | | |
|---|--|
| <input type="checkbox"/> Histotechnology | <input type="checkbox"/> Nursing: Traditional Track |
| <input type="checkbox"/> Medical Laboratory Science | <input type="checkbox"/> Nursing: Trad. Track + Gen. Education |
| <input type="checkbox"/> Nuclear Medicine Technology | <input type="checkbox"/> Nursing: Accelerated Track |
| <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Sleep Technology |
| <input type="checkbox"/> Practical Nursing | <input type="checkbox"/> Surgical Technology |
| <input type="checkbox"/> Radiography | |

3. **Classification:** Applicant Non - Graduate
 Gen. Ed. Prep(s) Freshman Sophomore I Sophomore II Junior Senior Graduate

4. **Service(s) Requested:**

- 4.1 Change of personal information (see back of form)
- 4.2 Enrollment Verification
- 4.3 Letter of Good Standing (Reflects financial good standing, must be cleared through Bus. Office)
- 4.4 Copy: CPR TB Immunization Record
- 4.5** Educational Reference.
 By (Faculty Name): _____ By (Faculty Name): _____
- 4.6 Patient Care Tech paperwork (Skills check-off sheet and evidence of completion of OSHA, HIPAA, and Corporate Compliance)
- 4.7 Other _____

5. **Submit Requested Information To:**

Name: _____

Fax

Mail

Pick-Up

Address: _____

City: _____ State: _____

Zip: _____ Fax #: _____

6. _____
 Signature Student ID # Date

**** Must be faxed and/or mailed according to BHCLR Policy.**

7. Change of Personal Information:
(Updated Social Security Card must be presented in order to make a name change).

For address change below, please indicate which address you would like to change:

Permanent **Mailing** **Both**

7.1 From: Former Name: _____
Former Address: _____
City: _____ State: _____ Zip Code: _____
Primary Telephone: _____
Secondary Telephone: _____
Emergency Telephone: _____

7.2 To: Current Name: _____
Current Address: _____
City: _____ State: _____ Zip Code: _____
Primary Telephone: _____
Secondary Telephone: _____
Emergency Telephone: _____

8. _____
Signature Student ID # Date

OFFICE USE ONLY			
Form received by:	_____ / _____	Forwarded to:	_____ / _____
	Signature Date		Admin. Staff name Date
Request filled by:	_____ / _____		
	Name	Date	
Social Security Card Verified By (only for name change):	_____		