

# APPLYING FOR ADMISSION



## FIRST-TIME STUDENTS

1. Complete the application and attach a recent photo.
2. Enclose the \$25 application fee (this fee is non-refundable).
3. Submit three references, which should include your pastor and two non-relatives.
4. Ask the high school you attended to send a copy of your transcript to:
- 5.

**Director of Admissions  
Shawnee Baptist College  
2633 Grant Line Road  
New Albany, IN 47150**

If, instead of a high school diploma you have received a GED, send an official copy of the results to the address listed above. Please include any partial high school transcripts.

5. Request that your ACT or SAT test scores be sent to the address listed above.
6. Complete the form regarding your health and medical history and submit it to the address listed above.

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## TRANSFER STUDENTS

1. Complete all steps for first-time students.
2. We must receive transcripts from all colleges or institutes you have attended, even if you do not wish to transfer the credits. Please have your transcripts sent to the address listed above.  
*Transcript Request forms may be duplicated, or additional forms are available upon request.*
3. SBC must be informed if you have any unpaid accounts with any other schools.
4. Notification of your status will be provided in writing upon receipt of all of the above information. Please call if you are unsure about the status of any part of your application.

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## PROCESSING OF APPLICATION

*Normally, an application will require at least three weeks to be processed, and in many cases, up to six weeks or longer. All information including transcripts, references, and the application fee should be sent in as quickly as possible so that a final letter of acceptance may be issued.*



APPLICATION FOR ADMISSION CONTINUED



FAMILY INFORMATION

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_
(Please indicate if deceased.)

Permanent Address: \_\_\_\_\_
Street City State Zip

Telephone Number: ( ) - Business Number: ( ) -

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_
(Please indicate if deceased.)

Permanent Address: \_\_\_\_\_
Street City State Zip

Telephone Number: ( ) - Business Number: ( ) -

PERSONAL INFORMATION

Name and address of current church membership: \_\_\_\_\_
Church

Name of Pastor: \_\_\_\_\_ Pastor's Home Phone: ( ) -
Street City State Zip Phone

Will you be applying for a scholarship at SBC? If yes, please check appropriate blank:

Valedictorian/Salutatorian Pastor's Recommendation Work Scholarship

Circle appropriate answer:

- Yes No Do you have any significant impairment?
Yes No Have you ever been treated for any nervous, mental, or emotional disorder, or been seen by a psychologist?
Yes No Have you ever used or sold illegal or dangerous drugs? If so, when was the last time?
Yes No Have you ever used alcoholic beverages? If so, when was the last time?
Yes No Have you ever used tobacco in any form? If so, when was the last time?
Yes No Were you ever expelled, dropped, or suspended by any school or college?
Yes No Have you ever been arrested for any reason? If yes, please give details:

Is there anything else in your background about which we should know? \_\_\_\_\_

How did you hear about SBC? \_\_\_\_\_

PERSONAL ESSAY

Please type or print in ink and include with your application.

Please prepare an essay on a separate sheet of paper (8 1/2 x 11) and incorporate the following subjects in your essay: a brief account of your salvation experience and a description of the work or ministry to which you feel God is calling you.

I certify that I have given full and complete information on this application for admission to Shawnee Baptist College and that I have listed all schools and/or colleges I have attended. Furthermore, if admitted, I pledge to conduct myself in accordance with the standards outlined in the catalog and the student handbook.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Be sure to enclose your \$25 application fee and mail to:

Director of Admissions
Shawnee Baptist College
2633 Grant Line Road
New Albany, IN 47150

# PASTOR'S RECOMMENDATION



*Please type or print in ink. Please fill out completely.  
If the pastor is a relative, please use an assistant pastor,  
youth pastor, or some other Christian leader for this reference.*

**Please mail to:  
Director of Admissions  
Shawnee Baptist College  
2633 Grant Line Road  
New Albany, IN 47150**

## **PART I:** (TO BE COMPLETED BY APPLICANT)

Name:  Mr.  Ms.  Mrs.

Mailing Address: \_\_\_\_\_  
Last First Middle Maiden  
Street City State Zip

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## **PART II:** (TO BE COMPLETED BY CHRISTIAN LEADER)

*The person named above has applied for admission to Shawnee Baptist College. We value your comments highly and ask that you give a complete and candid report so that fair consideration may be given to the applicant. Upon completion of this form, please return it to the Admissions Office at the address noted above. Do NOT give this form back to the applicant. For help with this form, please call (877) 949-1113.*

### **Confidential**

How long have you known the applicant?

Please describe your relationship with the applicant.

Please give your general impression of the applicant.

Please list the strengths of the applicant.

Please assess your perception of the applicant's potential for academic promise.

Please describe the spiritual maturity and Christian character of this applicant.

**PASTOR'S RECOMMENDATION CONTINUED**



Please rate the applicant on the following characteristics:

	Superior	Very Good	Average	Poor	Unknown
Dependability					
Moral Character					
Cooperation with others					
General Intelligence					
Integrity					

Would you recommend that we accept this applicant for admission?  
 With Enthusiasm     Strongly     With Reservation     Not At This Time

Name: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Church: \_\_\_\_\_

Church Address: \_\_\_\_\_

Daytime Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

# PERSONAL RECOMMENDATION



Please type or print in ink. Please fill out completely.

Please mail to:  
Director of Admissions  
Shawnee Baptist College  
2633 Grant Line Road  
New Albany, IN 47150

## PART I: (TO BE COMPLETED BY APPLICANT)

Name:  Mr.  Ms.  Mrs.

Mailing Address: \_\_\_\_\_  
Last First Middle Maiden  
Street City State Zip

Telephone Number: ( ) \_\_\_\_ - \_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## PART II: (TO BE COMPLETED BY FRIEND)

*The person named above has applied for admission to Shawnee Baptist College. We value your comments highly and ask that you give a complete and candid report so that fair consideration may be given to the applicant. Upon completion of this form, please return it to the Admissions Office at the address noted above. Do NOT give this form back to the applicant. For help with this form, please call (877) 949-1113.*

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How long have you known the applicant?

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Please list the strengths of the applicant.

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**PERSONAL RECOMMENDATION CONTINUED**



Please rate the applicant on the following characteristics:

	Superior	Very Good	Average	Poor	Unknown
Dependability					
Moral Character					
Cooperation with others					
General Intelligence					
Integrity					

Would you recommend  that we accept  this applicant for admission?  
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Name: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Church: \_\_\_\_\_

Church Address: \_\_\_\_\_

Daytime Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



# MEDICAL HISTORY



Please type or print in ink. Please fill out completely.

**Please mail to:**  
**Director of Admissions**  
**Shawnee Baptist College**  
**2633 Grant Line Road**  
**New Albany, IN 47150**

Name:  Mr.  Miss  Mrs.

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Maiden \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you intend to enroll:  Part-time?  Full-time?

Do you intend to live in the dormitories? Yes / No

Medical insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_

*If none, you must enroll for medical insurance through SBC upon registration.*

History of injuries: If any, give a short account. If none, please indicate. \_\_\_\_\_

History of operations: If any, please list. If none, please indicate. \_\_\_\_\_

List any medication you take regularly: \_\_\_\_\_

Have you ever sought psychiatric counsel? Yes / No

*If yes, please explain in a separate letter, including circumstances and medication which was given.*

## Student History (Check those you have had with an X)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS or HIV positive   | <input type="checkbox"/> Headaches (frequent)   | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Scarlet Fever          |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Sinus Disease          |
| <input type="checkbox"/> Chest Colds (frequent) | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Thyroid Disease        |
| <input type="checkbox"/> Chicken Pox            | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Tonsillitis (frequent) |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Trouble with eyes      |
| <input type="checkbox"/> Diphtheria             | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Drug Flashbacks        | <input type="checkbox"/> Malaria                | <input type="checkbox"/> Typhoid Fever          |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Measles                | <input type="checkbox"/> Weight Loss            |
| <input type="checkbox"/> Fainting Attacks       | <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Whooping Cough         |
| <input type="checkbox"/> Head Colds (frequent)  | <input type="checkbox"/> Pleurisy               | <input type="checkbox"/> Other: _____           |

## FAMILY HISTORY (Parents, grandparents, brothers & sisters)

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Leukemia         |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mental Disease   |
| <input type="checkbox"/> Brain Tumors | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Venereal Disease |

(Over for Physical Exam Form)

# PHYSICAL EXAM FORM



*This portion is not required for part-time or off-campus students.  
This form is not to be completed more than one year prior to enrollment.*

## To be completed by your physician:

Date: \_\_\_/\_\_\_/\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: \_\_\_\_\_

E.E.N.T.

Heart \_\_\_\_\_ Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_ Reflexes \_\_\_\_\_

Extremities \_\_\_\_\_ Genitals \_\_\_\_\_

Urine: Sugar \_\_\_ Albumin \_\_\_ Microscopic \_\_\_\_\_

TB Tine \_\_\_\_\_ Chest X-ray, if positive \_\_\_\_\_

The following blood tests are recommended, but not required:

VDRL \_\_\_\_\_ CBC \_\_\_\_\_

List any limitations below:

\_\_\_\_\_  
\_\_\_\_\_

Physician: \_\_\_\_\_ Name of Office: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street City State Zip

Is this person physically capable of being enrolled in school? Yes / No

# EMERGENCY PERMIT



Name: \_\_\_\_\_ Date: \_\_\_\_\_

In the event that an emergency should arise, I hereby give Shawnee Baptist College permission to authorize emergency anesthesia, surgery, and/or procedures deemed necessary.

*(This permit is required of every student. For a student under 21 years of age, the person legally responsible must sign for him.)*

\_\_\_\_\_  
*Signed*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City State Zip*

\_\_\_\_\_  
*Home telephone number*

\_\_\_\_\_  
*Emergency number*