



UWHealth

APPLICATION FORM

Orthoptic Program

Department of Ophthalmology

And Visual Sciences

University of Wisconsin Hospital and Clinics

2880 University Avenue, Rm 223

Madison, WI 53705

(608)263-6978

FULL NAME: _____

MAILING ADDRESS: _____

PHONE NO: Day _____ Eve _____ E-mail: _____

EDUCATION:

COLLEGE/UNIVERSITY/INSTITUTION	GRADUATION DATE	AREA OF STUDY/DEGREE

Are you a US citizen? Yes/No (circle one)

If not, country of citizenship _____ Are you a US Resident? Yes/No

Is English your primary language? Yes/No

If not, you are required to provide evidence of English proficiency. (TOEFL exam)

How did you learn about the Wisconsin Orthoptic Program?

How might you support yourself if accepted into this Program?

- In a **short hand written essay**, state why you are interested in a career as an Orthoptist, and describe any relevant work experience.
- Please forward **two letters of reference** and a **copy of you college transcript(s)**
- Optional: attach a **personal photograph** to your application materials

I certify that all the information I have provided on this application form and in all other admission application materials is complete, accurate and true to the best of my knowledge.

Applicant signature

Date