The following requirements are necessary for applicants requesting admission to the 600-hour Personal Training & Wellness Program:

**To be considered for admission, applicants must:**
1. Be at least 18 years of age;
2. Be a high school graduate or have a GED;
3. Submit a completed application packet;
4. Be physically, mentally and psychologically able to participate in fitness and personal training profession; and
5. Participate in an admissions interview with an Admissions Advisor.

**To be considered for admission, applicants must submit:**
1. A completed and signed application form;
2. A completed and signed health evaluation form;
3. A valid/current driver’s license; and
4. Two character references. Information must be completed on page two of this application.

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<table>
<thead>
<tr>
<th>Name: ____________________________________________</th>
<th>Gender: □ F □ M</th>
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<tbody>
<tr>
<td>Last First Middle Preferred</td>
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</table>

Race/Ethnicity (for Dept. of Education Statistics):
□ Nonresident alien □ Hispanic/Latino □ American Indian or Alaska Native □ Asian □ Other
□ Black or African American □ White □ Two or more races □ Hawaiian or Pacific Islander □ Unknown

<table>
<thead>
<tr>
<th>Home Address: ____________________________________________</th>
<th>Phone: Day (<em><strong>) ____________________ Evening (</strong></em>) ____________________ SS#: <strong><strong><strong>-</strong>_____-</strong></strong>___</th>
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<tbody>
<tr>
<td>(Current) Street City State Zip</td>
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Email Address: ____________________________________________ Birth date: ___/___/____

In case of emergency, contact: ____________________________ Relationship: __________________________

Emergency Contact’s Phone: Day (___) ____________________ Evening (___) ____________________

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Character References: (Do not list relatives. This section must be filled out completely.)

1. Name ___________________________ Relationship ___________________________
   
   Address ________________________________________________________________
   
   Phone (day) ___________________________ (eve) ___________________________

2. Name ___________________________ Relationship ___________________________
   
   Address ________________________________________________________________
   
   Phone (day) ___________________________ (eve) ___________________________

1. Describe any past professional or personal experience in the field of health and fitness including any professional sessions received, workshops, professional programs or trainings:

   ________________________________________________________________
   ________________________________________________________________

2. Education history (include high school, college, etc.)

<table>
<thead>
<tr>
<th>School</th>
<th>Dates</th>
<th>Area of Study</th>
<th>Results</th>
</tr>
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</tbody>
</table>

3. Do you have a learning disability or any other special circumstances that would interfere with the learning process? If so, explain.

   ________________________________________________________________

4. How did you first find out about WellSpring?

   ________________________________________________________________

5. Current Occupation: ___________________________ □ Full-time □ Part-time

   Current work hours: ________________________________________________

   Employer: _________________________________________________________ Phone (_____ ) ____________

6. Briefly describe your work history:

   ________________________________________________________________
7. Describe your current workout schedule and past experience with exercise.

8. Do you have any athletic background? If so, please list competitive history and number of years.

9. Have you ever been charged or convicted of a crime, including any misdemeanors or felonies? If yes, please provide complete details, including date, nature of offense and resolution.
   [ ] YES  [ ] NO

(Use additional sheets if necessary)

10. Briefly describe the following: (Use additional sheets if necessary)
    a. Why you want to attend WellSpring

11. What strengths and challenges do you perceive you will bring to your educational process?
WELLSPRING HEALTH EVALUATION

In the interest of your success, it is important that we assess your physical and psychological wellness status to determine whether there are any problems that would prevent you from fulfiling the requirements of this program. If contraindications exist, we will contact you for further discussion and/or recommendation. Students may be asked for a physician’s release if necessary.

This health evaluation will remain confidential and becomes part of your permanent student record. Please print and answer all questions. If the question is not applicable, please indicate so.

Name_________________________ Age _______ Hgt. _______ Wgt. _______

1. Name and phone number of primary health care provider:__________________________________________

2. List all medication(s) taken regularly (include herbs, aspirin, etc.) and describe the purposes for which they are taken:

   __________________________________________

   __________________________________________

3. Do you have any physical limitations? □ yes □ no Please describe:________________________

   __________________________________________

4. Are you currently pregnant, breastfeeding or planning on being pregnant in the next six months? □ yes □ no Please describe:__________________________________________

5. Are you presently receiving treatment for any reason? □ yes □ no Include counseling, alternative health care, substance abuse programs such as AA, etc. Please provide the name of the health advisor/counselor and phone number:

   __________________________________________

6. Have you ever been treated for mental or emotional disorders? □ yes □ no Please explain:

   __________________________________________

7. Describe injuries incurred due to accidents or sports:__________________________________________

   __________________________________________

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8. Please check all conditions that apply to you. **Please indicate present or past history.** If past history, please indicate the year:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>AIDS/ARC/HIV</td>
<td></td>
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<tr>
<td>Alcoholism/Drug Abuse</td>
<td></td>
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<tr>
<td>Allergies That Restrict Normal Activity</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Back Problems That Restrict Normal Activity</td>
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<tr>
<td>Blood Clots/Blood Clotting</td>
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<tr>
<td>Extremely High/Low Blood Pressure</td>
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<tr>
<td>Cancer</td>
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<td>Serious Circulatory Problems</td>
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<tr>
<td>Chronic Fatigue Syndrome</td>
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<tr>
<td>Convulsions/Seizures</td>
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<tr>
<td>Diabetes 1 or 2</td>
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<tr>
<td>Clinical Depression</td>
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<tr>
<td>Heart Issues (CAD, PAD, Angina, etc.)</td>
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<tr>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
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</table>

9. Describe any other illness, injuries or surgeries that restrict normal activity and strenuous exercise ability (include date). Students may be asked for a physician’s release if necessary.

I hereby certify that the above history is complete to the best of my knowledge. I grant WellSpring permission to contact the Primary Health Care Provider listed above in order to verify or further evaluate the answers herein this health evaluation.

________________________________________  __________________________
Applicant’s Signature                      Date

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ACCEPTANCE NOTIFICATION
Once you have met with an Admissions Advisor and your completed application packet is received and reviewed, you will be notified in writing as to your acceptance status. If you have been accepted, an appointment will be scheduled to enroll in the Program. During this meeting, an official enrollment agreement will be signed and payment will be made according to the tuition payment plan selected.

PLEASE READ AND SIGN
In addition to this form, I have submitted all the materials required for application as listed on page one of this Application. To the best of my knowledge, the information on the previous pages is accurate and correct. I understand that if any of the information provided is deemed untrue, the school may deny me enrollment into the school and/or dismiss me as a student under the terms of any contract between the school and me.

Applicant’s Signature ___________________________ Date ____________

Parent or Guardian’s Signature ___________________________ Date ____________
*If applicant is under 18 years of age*

EDUCATIONAL ATTESTATION
I certify that I have obtained either a High School Diploma or G.E.D. before entering this program. I agree to provide proof of documentation upon request to WellSpring.

Applicant’s Signature ___________________________ Date ____________

I acknowledge that I have received the WellSpring School of Allied Health Student Catalog.

Applicant’s Signature ___________________________ Date ____________

In connection with my application to the school, I understand that a credit report may be necessary to qualify for certain payment plans. I understand that such a report may contain public record information concerning previous employment and credit history.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED TO FURNISH THE ABOVE MENTIONED INFORMATION.

PLEASE PRINT
Full Name: ____________________________
*Last* ____________________________ *First* ____________________________ *Middle* ____________________________
Social Security Number: _____-___-_____
Home Address: ____________________________________________
*(Current) Street* ____________________________ *City* ____________________________ *State* ____________________________ *Zip* ____________________________

Applicant’s Signature ___________________________ Date ____________

Office Use Only: Date: ____________________________
Applicant Status: Accepted ____________ Not Accepted ____________ Asked to Reapply ____________
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