Metropolitan Community College – Penn Valley
Bachelor of Applied Science in Respiratory Care
2025 Program Application

Please complete all sections of this application thoroughly and accurately. Incomplete applications will not be considered. Please return completed application to:

Mail to:
Attn: Becky Paulsen
3444 Broadway Blvd.
Kansas City, MO 64111

Deliver in Person:
Becky Paulsen
Office 410 K
3444 Broadway Blvd.
Kansas City, MO 64111

Section 1: Applicant Information

Last Name: _____
First Name: _____
Middle Name: _____

If your name has appeared differently on any previous educational records, please list below:
Previous Last Name: _____
Previous First Name: _____
Previous Middle Name: _____

Mailing Address:
Street: _____
City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ – _____
Email Address: _____

Note: All correspondence from the Respiratory Care Program will be sent to this email address.

MCC Student ID Number: _____

Section 2: Education History

High School Attended: _____
Dates Attended: _____ to _____
Graduation Date or High School Equivalency Completion Date:
_____

Colleges Attended (begin with the most recent):

1. College Name: _____
   Dates Attended: _____ to _____
2. College Name: _____
   Dates Attended: _____ to _____
   (Attach additional pages if necessary)

Important: Request that official transcripts from all institutions attended be sent to:
Student Data Center
Metropolitan Community College
3200 Broadway, Kansas City, Missouri 64111
Electronic transcripts can be sent to: **transcripts@mcckc.edu**

Section 3: Work Experience

Please list your employment history beginning with the most recent:

1. **Employer Name:** _____
   Job Title: _____
   Dates of Employment: _____
2. **Employer Name:** _____
   Job Title: _____
   Dates of Employment: _____

(Attach additional pages if necessary)

Section 4: Volunteer and Personal Care Experience

Please list any relevant experience within the past five years. This may include **paid work**, **volunteer work**, or **personal caregiving experience** for someone who was sick, ill, or injured.

1. **Organization or Individual:** _____
   Role/Type of Care Provided: _____
   Dates of Experience: _____
2. **Organization or Individual:** _____
   Role/Type of Care Provided: _____
   Dates of Experience: _____

(Attach additional pages if necessary)

Signature of Applicant: _____
Date: _____