Dear Applicant,

Thank you for your interest in applying to the Sports Medicine Program (SPMD) at the University of North Georgia. The following packet has been constructed with a checklist to help you identify all of the required application materials that must be submitted to be considered for admission into the SPMD Program. Please be aware that the application process has recently transitioned to a digital/online format; you may access the online application at https://coeadmissions.ung.edu/.

You will be required to upload all documents that are listed in the applicant checklist with the exception of your two letters of recommendation. Physical letters of recommendation are to be sent to Ms. Sarah Snyder at the following address:

SPMD Admissions
University of North Georgia
82 College Circle, Dahlonega, GA 30533
Attn: Sarah Snyder

Digital letters of recommendation may be sent directly to sarah.snyder@ung.edu as long as they are sent directly from the reference’s primary email address and are not forwarded by the potential applicant.

Background checks are to be completed through CastleBranch using package code NB13. To complete your request, please find the following link: https://www.castlebranch.com/online_submission/package_code.php

If you have any additional questions regarding the SPMD Program or the application process, please direct all inquiries to Dr. Ryan Hipp (Ryan.Hipp@ung.edu). Please also find the link below to directly access the SPMD Program’s webpage to provide you with additional insight into the program, plan of study, and access to the online application: https://ung.edu/kinesiology/bachelors/b.s.-kinesiology-sports-medicine.php.
Sports Medicine Program Application Checklist

Please assure you have submitted the following application materials listed below as part of your online application.

Documents

- Application Checklist
- Application for Admission
- Current Transcript (highlight or circle current GPA)
- Observation Hours (50 required prior to start of the program in January)
  - Hours Already Obtained
  - Hours Remaining
- UNG SPMD Physical Form
- SPMD Immunization Form
- Proof of Current Health Insurance
- Proof of Current CPR/AED Certification
- Proof of Current First Aid Certification
- Proof of CastleBranch Background Check package code NB13
  (Screenshot of confirmation of order will suffice)
- Letter of Recommendation 1
- Letter of Recommendation 2
- Letter of Intent

To request this document in another format, contact Kathy Moody at kmoody@ung.edu or 706-864-1757
General Information:

Full name: __________________________________________________________

Student ID#: ___________________________ Gender: ___________________________

Home Address: ______________________________________________________

City: ___________________________ State: _______ Zip: ______________________

Phone: ___________________________

Address at UNG: ______________________________________________________

Phone at UNG: ___________________________

Academic Year: ___________________________

Current Grade Point Average: ___________________________

Transfer Students

College Attended: ___________________________ State: ______________________

Years Attended: ___________________________ Major: ______________________

Current GPA: ___________________________

Experiences

Athletic Training Experience: __________________________________________

____________________________________________________________________

Other Work Experience: __________________________________________

Memberships to Organizations: _______________________________________

Hobbies: ___________________________________________________________
## Sports Medicine Program Hours Log

**Student Name**__________________________ **Application Semester/Year**__________________________

**INSTRUCTIONS**: Each time you log observation hours under an Athletic Trainer outside of the UNG Athletic Training Facility, fill in the date, the facility, and list specific activities you performed or observed. Please list the total number of hours you observed for that session. For example, if you observed from 3 to 5 pm, you would list 2 hours in the Hours column. Place hours observed in ¼ hour increments and be sure to total your hours at the bottom of the page – hours not totaled will be considered incomplete. This form MUST be completed in INK. Complete a separate form for hours logged under different Certified Athletic Trainers.

**Athletic Trainer Name**__________________________ **BOC Number**__________________________

**Athletic Trainer Signature**__________________________ **Date**__________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Facility</th>
<th>Activities</th>
<th>Hours</th>
<th>AT Signature</th>
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<tbody>
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</table>

**TOTAL HOURS** __________
# University of North Georgia
Sports Medicine Program
Physical Evaluation Form

Name: ____________________________ Sex: M / F Age: ______ DOB (mm/dd/yy): ______
Personal Physician: ____________________________ Phone: __________
Address: ____________________________
In Case Of Emergency Contact – Name: ____________________________ Relation: ______
Address: ____________________________ Phone (H): ______ Phone (W): ______
Height: ______ Weight: ______ Pulse: ______ BP: ______
Vision: R 20/____ L 20/____ Corrected: Y / N Pupils: Equal ______ Unequal ______
Known Allergies: ____________________________

Medications currently used: ____________________________

<table>
<thead>
<tr>
<th>Medical</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
<th>INITIALS</th>
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</thead>
<tbody>
<tr>
<td>Appearance</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<tr>
<td>Lymph Nodes</td>
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<td>Heart</td>
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<td>Pulses</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitalia (males only)</td>
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<tr>
<td>Skin</td>
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<td>Musculoskeletal</td>
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<td>Neck</td>
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<td>Back</td>
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<tr>
<td>Shoulder/Arm</td>
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<tr>
<td>Elbow/Forearm</td>
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<tr>
<td>Wrist/Hand</td>
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<tr>
<td>Hip/Thigh</td>
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<tr>
<td>Knee</td>
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<tr>
<td>Leg/Ankle</td>
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<td></td>
<td></td>
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<tr>
<td>Foot</td>
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<td></td>
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</tbody>
</table>

☐ In my professional opinion, this patient meets minimum requirements to work as an Allied Health professional.
☐ In my professional opinion, this patient does not meet minimum requirements to work as an Allied Health professional.
Reason(s): ____________________________

__________________________ Date: __________
Physician Signature: ____________________________
Physician Address & Phone (if different from above): ____________________________
CERTIFICATE OF IMMUNIZATION
(Students are recommended to keep a photocopy of this completed form for future use.)
Medical records cannot replace this form.

PART A: TO BE COMPLETED BY STUDENT
Full Name: ___________________________. Signature: ___________________________

Student ID# ________________________

Date of Birth: _____/____/______ Expected Semester of Enrollment in SPMD Program: ____ 20____

PART B (REQUIRED IMMUNIZATIONS): TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER.

1. Measles, Mumps, Rubella. Required for students born in 1957 or later
   I. MMR (Measles, Mumps, Rubella)
      ___ two doses with the first dose at 12 months of age or later, AND the second at least 28 days after the first dose, OR
      ___ Laboratory/serologic evidence of immunity
      OR
   II. Measles
      ___ two doses with the first dose at 12 months of age or later, AND the second at least 28 days after the first dose, OR
      ___ Laboratory/serologic evidence of immunity or prior disease
   Mumps
      ___ one dose with the first dose at 12 months of age or later OR
      ___ Laboratory/serologic evidence of immunity or prior disease
   Rubella
      ___ one dose with the first dose at 12 months of age or later OR
      ___ Laboratory/serologic evidence of immunity
   OR
   III. Exemption
      ___ I was born before 1957, and therefore am exempt from this requirement

2. Tetanus-Diphtheria – Required of all students (Td booster in the last 10 years or Primary Series with DTaP, DTP or Td)
   ___ one Td booster dose within the last 10 years prior to matriculation, OR
   ___ Completion of primary series (Td, DTaP, DTP or Td) within the last 10 years prior to matriculation

3. Varicella – Required of all students (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years.)
   ___ History of disease
   ___ Laboratory/serologic evidence of immunity OR
   ___ one dose given at 12 months of age or later, BUT before the student’s 13th birthday, OR
   ___ two doses with the first dose given after the student’s 13th birthday, AND the second dose at one month after the first dose

4. Hepatitis B – Required of all students who are 18 years of age or younger (Three doses of vaccine or a positive Hepatitis surface antibody
   ___ three-dose hepatitis B series, OR
   ___ three-dose combined hepatitis A and hepatitis B series, OR
   ___ two doses hepatitis B series of Recombivax, OR
   ___ Laboratory/serologic evidence of immunity or prior infection
   ___ I am 19 years of age or older and are therefore not required to be immunized for Hepatitis B

5. Exemption
   ___ This student is exempt from the above immunization on grounds of permanent medical contraindication
   ___ This student is temporarily exempt from the above immunizations until _____/____/____

Health Care Provider-Immunization status indicated above is certified by:

________________________________________________________________________

Name and address of health care provider

Signature of physician or health care provider and Date ________________________________