University of Arkansas for Medical Sciences College of Medicine
Arkansas Resident Status for Initial Classification Form

This document, when completed and submitted to the College of Medicine Office of Medical Student Admissions, will provide information necessary for making residency determinations of applicants in accordance with the UA Board of Trustees policy 520.8. For an applicant who indicates that his/her legal state of residence is **Arkansas** on the AMCAS application, **all questions appearing on this form must be answered**. Birth and/or prior residence in the State on the part of the applicant and/or parents do not, in itself, establish Arkansas resident status. Of critical importance is the current status of the applicant. The relevant time period is the twelve month period prior to the time of application. An Arkansas resident who leaves the state solely to attend an out-of-state school retains residency in Arkansas, since residing in a state solely to pursue an education does not establish residency. Similarly, an applicant residing in Arkansas for the sole purpose of pursuing an education at a school of higher education in Arkansas cannot use the time enrolled as a student to establish Arkansas residency. Your application for admission cannot be processed until your resident status is determined. Please be forewarned that withholding or falsifying any answers may disqualify you either prior to or subsequent to admission to the College of Medicine.

Name: _____ _____ _____ **AMCAS ID #:** _____

Last First Middle

Permanent Address: _____

Street and Number (P.O. Box is **not** acceptable)

_____ _____ _____ _____

City County State Zip Code

Present Address: _____

Street and Number (P.O. Box is **not** acceptable)

_____ _____ _____ _____

City County State Zip Code

Since what date? From: _____ To: _____

How many years (or months if less than one year) have you lived in Arkansas? _____ Years _____ Months If the addresses listed for permanent and present are different, please provide the reason in the space below:

High School Attended and Graduation Date:

_____ _____ _____

Name of School City / State Year Graduated

List any employment (list in chronological order beginning with most recent)

Employer	Location (City, State)	Dates Employed

As further evidence that the applicant has established a home of permanent nature in Arkansas as manifested by Good Faith Acts, please respond to the following:

If employed, have you ever filed an Arkansas state tax return? Yes _____ No _____

Do you have a current Arkansas driver's license? Yes _____ No _____ _____
If yes, County of issue

If you own a vehicle, is the automobile registered in Arkansas? Yes ____ No ____ NA ____

Where are you registered to vote? _____ _____ _____
(or N/A if not registered) State County Registration Number

Parents: Married ____ Divorced ____ Separated ____ Single ____ Deceased _____

Father:	Mother:
_____	_____
Name	Name
_____	_____
Present Address	Present Address
_____	_____
City / State / Zip code	City / State / Zip code

Are your parents currently residents of Arkansas? (yes/no) Father _____ Mother_____

If yes, for how long (years/months)? Father: _____ Mother: _____

Are you self-supporting? No _____ In Part _____ Entirely _____

Are you claimed as a dependent for state and/or federal income tax purposes by:

Parent(s): Yes ___ No ___ **Spouse:** Yes ___ No ___ NA ___ **Other:** Yes ___ No ___

Do you claim residence in another state for any purpose? ____ ____ _____
Yes No If Yes, what State? **Please use this section to provide any additional or clarifying comments:**

By signing this form, I attest that all information is true and accurate and I am responsible for notifying the University of Arkansas for Medical Sciences, College of Medicine, Office of Medical Student Admissions of any changes which might affect residency status. I understand that any applicant who knowingly gives erroneous information or fails to present corrected or updated information may be subject to dismissal from the College of Medicine's application process or its medical school programs.

_____ _____
Applicant Name (your typed name will be your signature) **Date**