



2008-2009 RESPIRATORY THERAPY PREREQUISITE VERIFICATION

Print: _____ Student I.D. #: _____
 Last name First name
 Address: _____ E-mail _____ DOB ____/____/____
 Number Street
 _____ Home Phone: (____) _____ - _____
 City zip code

List any classes you are enrolled in now:

Course and Number:	College	Section Number	Name of Instructor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date you Applied to LAVC _____ (this date will be verified by the Admissions Office)
 List any completed college/university degrees
 College _____ Degree / Discipline _____ Grad date _____
 College _____ Degree / Discipline _____ Grad date _____
 If you have already completed **RT 2**, School _____ Date _____ Grade _____
 Have you ever been accepted into a LACCD RT or RN Program Yes No
 If Yes – then list school and date accepted. School _____ Date _____

Credit for foreign coursework must have already been approved by the Los Angeles Valley College Petitions Committee. All information on this form is subject to verification by LAVC. Failure to provide complete and accurate information or transcripts will result in denial of the student's application for enrollment to the RT program and courses.

Student Signature _____ **Date** _____

**(THIS SECTION TO BE COMPLETED BY COUNSELOR OR DIRECTOR)
 RT PROGRAM PREREQUISITE VERIFICATION**

Requirement	Name of School	Course Name and Number	Semester/Year Completed or In-Progress	*Sem./Qtr. Units	Grade if Completed
Chemistry 51 – or higher level w/ lab					
Microbiology 20					
Physics 5					
Physiology 8 or Anatomy 1 - min. 4 sem./6 qtr. units					
Physiology 9 or Physiology 1 - min. 4 sem./6 qtr. units					
Psychology 1					
Res. Therapy 1					

*All above prerequisites must total at least 13 semester/19.5 quarter units.

LAVC Counselor or RT Program Director Signature _____ **Date** _____