

# University of Notre Dame Presidential NROTC Preparatory Scholarship Application



Personal Information				
Name (Last, First, Middle)			Phone	
Current Mailing Address		Name of Parent/Guardian		
Place of Birth		Address of Parent/Guardian		
Date of Birth				
Are you a US Citizen?		If Naturalized, give date, place, court of jurisdiction, and certificate number.		
YES      NO				
Gender				
Male      Female				
What is your race? <small>Mark one or more of the categories below to indicate how you identify your race.</small>		Ethnic Background (Optional)		
American Indian/Alaskan Native		Aleut	Korean	Other Asian Descent
Asian		Chinese	Latin American w/ Hispanic Descent	US/Canadian Indian Tribes
African American/Black		Cuban	Melanesian	Other Hispanic Descent
Native Hawaiian/Other Pacific Islander		Eskimo	Mexican	Other Pacific Island Descent
Caucasian		Filipino	Micronesia	Polynesian
				Puerto Rican
Email Address		Intended Major or Area of Study (Tier 1 or Tier 2 only)		
Parent/Legal Guardian's Previous Military History				
Parent/Legal Guardian	Branch	Rank/Rate	Status (Active/Retired)	Commissioning Source
Extracurricular Activities				
<small>READ CAREFULLY: Identify only those activities in which you engaged during school grades 9-12. NROTC is particularly interested in identifying activities in which an applicant has participated involving responsibility and leadership. Examples: NJROTC, Student Government, Eagle Scout, etc...</small>				
Organization	Positions Held	Hours/Week	Grades of Participation	
			9	10 11 12
			9	10 11 12
			9	10 11 12
			9	10 11 12
Athletic Activities				
<small>READ CAREFULLY: Identify only those sports in which you engaged during school grades 9-12. Mark the year(s) in which you were on the varsity team. If you 'lettered' in the sport list that in the awards. Mark 'JV/Club' if you participated at this level in any year. Do not list intramural activity.</small>				
Sport	Positions Held	Awards/Recognition	JV/Club	Grades of Participation
				9 10 11 12
				9 10 11 12
				9 10 11 12
				9 10 11 12
Other Activities				
<small>Attach additional sheets, if needed, to identify other activities not listed above that involve considerable responsibility and leadership. List positions held and the average number of hours devoted per week to the activity.</small>				

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### Employment

List in reverse chronological order beginning with the most recent, each period of full-time, part-time, or self-employment. List inclusive dates for each period. If discharged for cause from any employment, so state. Include any leadership responsibilities.

Dates		Employer Name, Address & Phone Number	Hours/ Week	Type of Work Performed
From	To			

### Volunteering

READ CAREFULLY: Identify only those volunteering activities in which you engaged during school grades 9-12. List the number of hours performed per year in the box corresponding to the correct school year and volunteer activity. If other is selected, please include a brief description of your volunteer work in the remarks. Attach additional sheets if more space is needed.

Grade	9	10	11	12	Volunteer Work Remarks
Hospital / Candy Striper					
With Handicapped Elderly					
Tutor / Coach Children					
Other					
Total Volunteer Hours Per Year					

**Essay 1: Why do you want to become a Commissioned Officer through University of Notre Dame? (400 words or less)**

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**Essay 2: Have you experienced any adversity in your life (parents divorced, single parent family, multiple high schools, frequent moves etc.). If so, describe the circumstances and how you met the challenges. (400 words or less)**

Answer the following questions. If you answer 'Yes' provide explanations on an additional sheet.	Yes	No
1. Have you ever applied for or signed any agreement concerning any program leading to a commission in any of the Armed Forces of the United States? (If 'Yes', list the date, place of application, program applied for and current status of application.)		
2. Have you signed an Enlistment Contract (DD Form 4) with any of the Armed Forces of the United States? (If 'Yes', list the date, place, service, and current status of enlistment.)		
3. Have you ever been arrested, detained, indicted, summoned into court, or convicted for any violation of civil or military law, including juvenile offenses and moving traffic violations? (If 'Yes', give complete description of incident, name and place of court, nature of offense, date, and disposition)		
4. Are you currently awaiting trial or sentence, on probation, under suspended sentence, or under any other type of military or civilian restraint as a result of violation of law or regulation?		
5. Have you ever been known by any other name or names other than that used in this application? (If 'Yes', explain in affidavit form and submit with application, even if differences were only differences in spelling.)		
6. Do you have any moral obligations or personal convictions that will prevent you from conscientiously bearing arms and supporting and defending the constitution of the United States against all enemies, foreign and domestic?		
7. Have you ever taken any narcotic, sedative, or tranquilizer drugs other than as prescribed by a physician or dentist? (If 'Yes', attach a statement with the full circumstances, number of time used, amounts taken, period over which taken, and intent for further use.)		
8. Have you ever been arrested or convicted of trafficking illegal drugs?		
9. Have you ever used LSD, marijuana, sniffed glue or used any other hallucinogens, hypnotic, stimulants, or other known harmful or habit-forming drugs and/or chemicals? (If 'Yes', attach a statement with the full circumstances, number of times used, amounts taken, period over which taken, and intent for further use.)		

I certify that all information given by me is complete and correct to the best of my knowledge.  
I understand that this applicant questionnaire does not obligate me in any way, and that I may withdraw my application at any time.

Applicant Signature	Date
Parent/Legal Guardian Signature	Date

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Medical History					
Height	Weight	Date of Last Sports Physical / Private Sector Physical			
Answer the following questions. If you answer 'Yes' provide explanations in block 41			Yes	No	
1. Eye trouble (to include vision loss, cataract, glaucoma, keratoconus, corneal ectasia, retinal detachment)?					
2. Surgery to improve vision (PRK, LASIK, LASEC, RK, intraocular lens implant, cross linking)?					
3. Color vision deficiency?					
4. Ear trouble (to include perforated ear drum, tubes in ears, or other ENT surgery)?					
5. Loss of balance or vertigo?					
6. Hearing loss or use of a hearing aid?					
7. Nose, throat, or sinus trouble (to include sinusitis, abscess, surgery on nose, sinuses or throat)?					
8. Orthodontic treatment? (if "yes", include completion or projected date of completion in block 41)					
9a. Tooth or gum trouble (excluding cavities)?					
9b. Date of last dental exam:					
10. Breathing trouble (to include asthma, wheezing, shortness of breath, chronic cough, use of inhaler, collapsed lung)?					
11. Cardiac trouble (to include chest pain, palpitations, heart valve problems, surgery, high or low blood pressure)?					
12. Gastrointestinal trouble (to include celiac disease, irritable bowel syndrome, ulcer, reflux, esophagitis, gallstones, hernia, or hepatitis)?					
13. Inflammatory bowel disease (to include Ulcerative colitis or Crohn's disease)?					
14a. Gynecologic trouble (including endometriosis, polycystic ovarian disease, abnormal pap smear)? (females only)					
14b. Date of last menstrual period (females only):					
14c. Date of Last PAP smear (females only):					
15. Testicular or prostate trouble? (males only)					
16. Orthopedic problems of the back or neck?					
17. Orthopedic problems of the upper extremities (fracture, dislocation, sprain, surgery)?					
18. Orthopedic problems of the lower extremities (fracture, dislocation, sprain, surgery)?					
19. Vascular trouble (Raynaud's disease, blood clot or deep venous thrombosis, high blood pressure)?					
20. Skin trouble (to include psoriasis, eczema, atopic dermatitis, severe acne)?					
21. Prescribed systemic retinoid medications (i.e.: Accutane)? (List date completed or projected completion date in block 41.)					
22. Blood disorders (anemia, thrombocytopenia, bleeding disorders, disorder of the spleen)?					
23. Allergic reaction to food, medications, insects?					
24. A positive PPD or been treated for tuberculosis?					
25. Car, train, sea, or air sickness that required prescription medication or avoidance of travel?					
26. Endocrine disorders (including diabetes, thyroid, osteoporosis)?					

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Medical History (Continued)	Yes	No
27. Head injury, memory loss, amnesia?		
28. Neurologic trouble (including dizziness, fainting spell, seizure, paralysis)?		
29. Frequent or severe headaches in the past 2 years?		
30. Sleeping trouble (narcolepsy, sleepwalking, chronic insomnia, sleep apnea)?		
31. Evaluation or treatment for depressive disorder?		
32. Evaluation or treatment for anxiety disorder or panic attacks?		
33. Evaluation or treatment for eating disorders (anorexia or bulimia)?		
34. Evaluation or treatment for attention deficit hyperactivity disorder, attention deficit disorder, or learning disability?		
35. Tumor or cancer?		
36. Cold or heat injury?		
37. Rhabdomyolysis?		
38. Have you been prescribed medications in the last 12 months? (if "yes" list names, reason, and approximate dates used in Block 41)?		
39. Have you EVER been hospitalized (including psychiatric)?		
40. Have you EVER been rejected or discharged for military service for any reason?		

**Medical Comments**

41. Explain all "Yes" answers to questions 1-40 above. Begin with the Item Number. Describe answer(s): provide date(s) of problem(s) /condition(s); provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evaluation and/or treatment); and describe your current medical status (ongoing/resolved). Attach additional sheet(s) if necessary and sign and date each additional page. Obtain and attach copies of applicable medical evaluation and treatment records if requested.

I certify that all medical information provided by me is complete and correct to the best of my knowledge.

Applicant Signature	Date
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