UNIVERSITY OF
SOUTH DAKOTA
SCHOOL OF HEALTH SCIENCES
2020-2021

University of South Dakota - Social Work Department

Bachelor of Science in Social Work (BSSW) Application

Application Deadline is October 10th every year.

The University of South Dakota, School of Health Sciences is committed to an environment of inclusiveness in classroom and clinical settings that honors the richness of diverse perspectives and inter- professional practice through valuing diverse traditions, heritages, and experiences.

The University of South Dakota strives to foster a globally inclusive learning environment where opportunities are provided for diversity to be recognized and respected. To learn more about USD's diversity and inclusiveness initiatives, please visit the website for the Office for Diversity.

Any student who feels they may need academic accommodations or access accommodations based on the impact of a documented disability should contact and register with Disability Services during the first week of class or as soon as possible after diagnosis of a disability. Disability Services is the official office to assist students through the process of disability verification and coordination of appropriate and reasonable accommodations. Students currently registered with Disability Services must obtain a new accommodation memo each semester.

Please note: if your home institution is not the University of South Dakota but one of the other South Dakota Board of Regents system institutions (e.g., SDSU, SDSMT, BHSU, NSU, DSU), you should work with the disability services coordinator at your home institution.

Disability Services, North Complex Commons 116
Phone: 605-658-3745
Fax: 605-677-3172
Web Site: www.usd.edu/ds
Email: disabilityservices@usd.edu

Accessibility Statement
The University of South Dakota strives to ensure that physical resources, as well as information and communication technologies are accessible to users in order to provide equal access to all. If you encounter any accessibility issues, you are encouraged to immediately contact the instructor of the course and the Office of Disability Services which will work to resolve the issue as quickly as possible.

Thank you for your interest. If you have any questions about the application process, please call us at 605-658-5940 or e-mail at socialwork@usd.edu. We look forward to receiving your Application for Admission.

Personal Information

1. Name: _____

   Last First Middle

2. Other name(s), if any, that may appear on academic records _____
3. USD ID Number: _____
4. Gender Identity: _____
5. Race/ Ethnicity: _____
6. What is your state of residency? _____
7. Date of Birth: _____
8. Current Address

   _____
   Street

   _____
   City

   _____
   State Zip Code

9. Permanent (Home) Address, if different

   _____
   Street

   _____
   City

   _____
   State Zip Code

10. Cell Phone: _____
12. USD E-mail: _____
13. Alternate E-mail: _____
14. USD Minor: _____ or Associate Degree: _____
    Month/ Day /Year
15. Total credits hours completed: _____
16. Do you request consideration for modified Four-Year plan? You must have over 70 credit hours completed at time of application to be considered.

REQUIREMENTS of the Program:

Successful completion of social work and non-departmental courses with a "C" or higher grade and 50 or more credit hours by the end of the current fall semester. Overall G.P.A. of at least 2.3. *Include recent transcript from all universities*

	Grade Received OR	**Expected Semester of Completion**
SOC 100 or SOC 150		
PSYC 101		
POLS 100		
PHIL 220, or REL 250 or ADS 412 or A&S 140		
Any Lab Science _____ For Graduate Study a human biology course is recommended		
SOCW 200		
Register for the classes below in the Fall of your Junior Year		
SOCW 210		
SOCW 320		
SOCW 340		

1. Submit Application in October of Junior year

2. A letter from your supervisor supporting that you have completed 60 hours of volunteer or paid social/human service experience. The letter from your paid or volunteer experience supervisor must verify the hours and activities you participated in.

3. A letter of reference from a current or former non-social work professor or employer. This letter needs to come from someone other than the person verifying your 60 hours of volunteer/paid service. For instance, a former non-social work professor or a past employer

4. Your Personal Statement (See Guidelines for Preparation on page 5 of application)

Additional Requirements

1). The USD School of Health Sciences requires the completion of all Immunizations listed on the separate Immunization Form prior to beginning your Field Experience SOCW 496. I understand that I cannot enroll in SOCW 496 until the BSSW program has been notified of my compliance. Students are to provide proof of Immunizations to the University of South Dakota's Student Health Representative located at the Sanford Student Health Clinic. Students must also sign the Release of Information Form (ROI) allowing the University representative to inform the program of Immunization completion or deficits. The School of Health Sciences Immunization policy is in the BSSW Program Student Handbook. The ROI and Immunization Form is provided in a separate attachment.

I understand it is my responsibility to comply with the School of Health Sciences Immunization Policy.

_____ Yes _____ No

_____
Student Signature

2). The USD School of Health Sciences Policy is that every student admitted to an educational preparation program in the School of Health Science must submit to a Criminal Background Check. The Criminal Background check will be initiated by you only after you have received notice of your admission to the social work program. The policy, procedures and instructions on how to complete a criminal background check will be provided at that time. Please note felony convictions and numerous misdemeanors may complicate eligibility for social work licensure as well as a capacity to obtain liability insurance as a student or professional.

Please indicate your willingness to submit to and pay for a criminal background check if you are accepted into the social work program. All background checks must be completed by the first week of August. Indicate yes or no in the space provided below.

_____ Yes _____ No

3). I understand it is my responsibility to comply with the BSSW Program Student Handbook. I further understand my successful completion of the program is dependent upon said compliance.

_____ Yes _____ No

If you have concerns or objections to the Immunization requirements for the Program or questions about the possible consequences of criminal activities, please discuss such concerns with your Social Work advisor.

Please complete the following questions relative to your background.

BEFORE RESPONDING, PLEASE READ EACH QUESTION CAREFULLY

Have you ever been convicted, pled guilty or no contest, or been granted a deferred judgment or sentence, or suspended imposition of sentence, with respect to a misdemeanor or felony offense including drug and alcohol convictions.

_____ Yes _____ No

If yes, please provide the details.

Do you have any criminal charges, misdemeanor or felony, currently pending against you in any state or country?

_____ Yes _____ No

If yes, please provide the details.

The School of Health Sciences health professions programs reserve the right to deny admission to any applicant based on the best interest of the profession.

I certify that all of the information contained in these application materials is complete and correct. I understand that any false, misrepresented or missing information may be cause for denial of my application for admission to the Social Work Major. Further, in the event that my acceptance into the program has been granted prior to the discovery of false, misrepresented, or missing information, such discovery may be cause for dismissal from the Social Work Major. I also understand that admission or graduation from a health professions program does not guarantee obtaining a license to practice. Licensure requirements and the subsequent procedures are the exclusive right and responsibility of the state Boards regulating professional practice. I also verify I am familiar with the BSSW Student Handbook where maintaining good standing is defined and consequences of failure to do so are explained. I commit to uphold such standard in the completion of the BSSW Program.

_____

Student Signature Date

Guidelines for Preparation of Personal Statement

Application for Admission to the

Social Work Major

Please prepare a personal statement that is 3-4 pages long and use APA format. APA format is written in Times New Roman 12 point font with one-inch margins on all sides, double-spaced without extra space between paragraphs. Use subheadings that are centered and boldface for these five sections:

- How your plans for the future are similar to social work values (Your paper from SOCW 200 is a great start)
- Your personal strengths.
- Areas in which you hope to grow professionally.
- Your communication skills.
- Your experience(s) with diversity.

All required materials are to be mailed or returned to: The
Social Work Department
University of South Dakota
Julian Hall Room 253
414 East Clark Street
Vermillion, South Dakota 57069-2390

University of South Dakota
Undergraduate Social Work Program

AUTHORIZATION TO RELEASE REFERENCE INFORMATION

I hereby authorize the University of South Dakota, Department of Social Work, to release information regarding my academic and field work performance within the Social Work Program to prospective employers and/or academic institutions. Release of such information will be made only to those individuals, agencies and/or institutions that I specifically authorize to receive information. This authorization may be revoked at any time by written request.

NAME: _____ SIGNATURE: _____
(Print Clearly)

DATE: _____

AUTHORIZATION FOR INFORMATION RELEASE

I hereby authorize the University of South Dakota, Department of Social Work, to use my limited personal information such as address, telephone, e-mail, photo, and job placement for marketing purposes only. This authorization may be revoked at any time by written request.

NAME: _____ SIGNATURE: _____
(Print Clearly)

DATE: _____

Volunteer or Paid Experience

Verification of 60 hours or more

In a Helping Service Field

In the verification of volunteer or paid experience, please list the duties the prospective student has assumed in your agency and verify that the student has been engaged in those activities for at least 60 hours or more. In addition to the verification of hours please provide a statement about how well they performed (strengths) and areas they may need to improve as they prepare for professional practice in the field of social work.

Thank you for your support.

Name of agency:

Name of person writing the reference:

Position of person writing the reference:

Name of prospective student you are writing the reference for:

Verification of hours (how long the student has worked/volunteered in the agency)

Please provide a short statement of duties the student has performed. In the statement of duties note what you would consider strengths also note any areas needing improvement.

Recommendation for

A Career in a Helping Service Field

Thank you for your support.

Name of person writing the reference:

Name of agency or type of work the person writing the reference is engaged in: Name of

prospective student you are writing the reference for:

How you know the student applying for the Bachelor of Science in Social Work Degree?

Please provide a short statement of how, and how long you have known the student. Describe

what you consider strengths of the student.

If possible, tell us about the student's preparation for the helping professions and any areas you assess as needing improvement.

You may e-mail this document to: Tammy Goetz, Tamara.Goetz@usd.edu

Send completed immunization form electronically to:
usd.immunizations@SanfordHealth.org

Or drop the hard copy form off at USD Student Health located on the first floor of the Sanford hospital at 20 South Plum, Vermillion, SD

Patty Waage, RN
RN Immunization Coordinator
Sanford Hospital
Route 8810, 20 South Plum Street
Vermillion, SD 57069
Phone: 605-677-3504
Fax: 605-677-3701
usd. immunizations@sanfordhealth.org

All immunizations do not need to be completed when submitting the application. They do need to be completed the semester before you do Field (SOCW 496).

University of South Dakota Health Sciences
REQUIRED IMMUNIZATION FORM

Name **DOB** USD ID#

Program: Addiction Studies [ ] Dental Hygiene [ ] Health Science [ ] Medical Laboratory Science [ ] Medicine [ ] Nursing [ ] Occupational Therapy [ ] Physical Therapy [ ] Physician Assistant [ ] Public Health [ ] Social Work [ ] Master of Social Work [ ] Health Science Major Paramedic Specialization [ ]

Health Affairs Requirements: For students in programs requiring full compliance with the USD Health Affairs Immunization Policy, this form must be completed with the appropriate signatures.
Include copies of titer reports and other medical records when applicable.

REQUIRED IMMUNIZATIONS:

A. **MMR (Measles, Mumps, Rubella) Vaccine.** Two doses required for all students born after 12/31/56.
Dates: 1.____/____/_____ 2. _____/_____/_____

OR individual vaccine/proof of immunity as noted below.

1 **Measles** (Rubeola)
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR

Has report of positive immune titer. Date:____/_____/_____ **ATTACH LAB REPORT**

2 **Rubella** (German Measles)

Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR

Has report of positive immune titer. Date:____/_____/_____ **ATTACH LAB REPORT**

3 **Mumps**
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR

Has report of positive immune titer. Date:_____/_____/_____ **ATTACH LAB REPORT**

B. **Date of Tdap (tetanus, diphtheria, adult pertussis):** Date:_____/_____/_____
If longer than 10 years; date of latest booster Date:_____/_____/_____***Td or Tdap (circle one)***

C. **Varicella** (Chicken Pox) One of the following is required:

Documentation of positive varicella titer. Date:_____/_____/_____ **ATTACH LAB REPORT**
OR
Vaccine: Two doses are required for those without evidence of immunity. Recommended interval is 4-8 weeks between doses.
Dates: 1._____/_____/_____ 2._____/_____/_____

D. **Hepatitis B Vaccine** - Three doses and positive titer required.*(If unable to obtain dates of immunizations a positive titer is acceptable*)

1st dose Date:_____/_____/_____
2nd dose Date:_____/_____/_____ (1 month after 1st dose)
3rd dose Date:_____/_____/_____ (6 months after 1st dose)

AND

Hepatitis B Titer (HbsAB or Anti-HBs – hepatitis B surface antibodies)
Immunity demonstrated by hepatitis B titer - **ATTACH LAB REPORT**

Date:_____/_____/_____ Positive/Reactive____ Negative/Nonreactive____

University of South Dakota Health Sciences
REQUIRED IMMUNIZATION FORM

Name **DOB** USD ID#

E. **Tuberculosis Skin Test** - PPD (Mantoux) – Two-step TB skin test required initially or Interferon Gamma Release Assay

Two-Step TB Skin Test; recommended 1-3 weeks apart.***Note** *any two documented TB skin tests completed within a 12 month period shall be considered a two-step.*

Step 1 (Date placed) ____/____/____ Step 1 (Date read) ____/____/____ Results:_____mm

Step 2 (Date placed) ____/____/____ Step 2 (Date read) ____/____/____ Results:_____mm

If two-step was completed more than 12 months prior to start of classes, an annual TB skin test is required

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

Interferon Gamma Release Assay (IGRA): Date:_____/_____/_____Positive_____Negative_____

ATTACH LAB REPORT

History of Positive TB Skin Test:

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

ATTACH COPY OF CHEST X-RAY REPORT AND DOCUMENTATION FROM HEALTHCARE PROVIDER.

See immunization policy.

History of BCG vaccination: Date _____/_____/_____(TB skin test required regardless of prior BCG vaccination)

F. **Influenza vaccine.** Required by Dec. 1st annually Date:_____/_____/_____

Not required prior to admission if starting in the summer or fall

RECOMMENDED IMMUNIZATIONS:

G. **Meningococcal Vaccine (Meningitis vaccine)**. Meningococcal Vaccine (Meningitis vaccine). Refer to immunization policy. Students should consult with their physician about their specific risk:

Vaccine:_____Date:_____/_____/_____ Vaccine:_____Date:_____/_____/_____

H. **Childhood DTP/TDaP/DPT immunizations:**

Dates of Primary Series: 1.____/_____/_____ 2._____/_____/_____ 3._____/_____/_____

4.____/_____/_____ 5._____/_____/_____

I. **Polio immunizations:**

Dates of Primary Series: 1.____/_____/_____ 2._____/_____/_____ 3._____/_____/_____

4.____/_____/_____ 5._____/_____/_____ Type of vaccine: Oral (OPV)_____ Inactivated (IPV)_____

SIGNATURE X _____ **Date** ___/___/___

Must be signed by Healthcare Provider (Physician, PA, NP, Nurse)

PRINT NAME _____

Hospital/Clinic Address of physician or nurse verifying this information: Hospital/Clinic Phone #_____

_____

_____

A copy of titer/lab reports must be provided with this form as indicated above. *Updated 3/23/2018*