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.*

If you are a prospective student with a disability and need assistance or accommodations during the admission/application process, please contact the Director of Disability Services, University of South Dakota, 414 East Clark Street, Vermillion, SD 57069. Phone: 605-677-6389 Fax: 605-677-3172 Email: dservice@usd.edu

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? ________________ Number of years? __________

7. Date of Birth: __________________
   Month/ Day /Year
8. Current Address

<table>
<thead>
<tr>
<th>Street</th>
<th>Street</th>
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<tbody>
<tr>
<td>City</td>
<td>City</td>
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<tr>
<td>State</td>
<td>Zip Code</td>
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9. Permanent Address, if different

<table>
<thead>
<tr>
<th>Street</th>
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<tbody>
<tr>
<td>City</td>
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<tr>
<td>State</td>
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10. Cell Phone: __________________________

12. USD E-mail: __________________________

13. Alternate E-mail: ____________________

14. USD Minor: ____________________________ or Associate Degree: _________________________
**REQUIREMENTS of the Program:**

Successful completion of social work and non-departmental courses with a “C” or higher grade. Good standing (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 a*

<table>
<thead>
<tr>
<th>Course</th>
<th>Grade Rcvd</th>
<th>Expected Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC 100 or SOC 150</td>
<td></td>
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<tr>
<td>PSYC 101</td>
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<tr>
<td>POLS 100</td>
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<tr>
<td>PHIL 220, or REL 250 or ADS 412 or A&amp;S 140</td>
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<tr>
<td>One of the following lab sciences</td>
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<tr>
<td>BIOL 103/L</td>
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<tr>
<td>BIOL 104/L</td>
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<tr>
<td>BIOL 151/L</td>
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<tr>
<td>BIOL 153/L</td>
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<td>ANAT 142</td>
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<tr>
<td>Or</td>
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<tr>
<td>1 of the following courses. Please note - they do not satisfy the <strong>lab science</strong></td>
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<tr>
<td>BIOL 105</td>
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<td>HSC 280</td>
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<tr>
<td>MICRO 230</td>
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<tr>
<td>SOCW 200</td>
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</table>

**Register for the classes below in the Fall of your Junior Year**

<table>
<thead>
<tr>
<th>Course</th>
<th>Grade Rcvd</th>
<th>Expected Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOCW 210</td>
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<tr>
<td>SOCW 320</td>
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<tr>
<td>SOCW 340</td>
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</tbody>
</table>
• Submit Application in October of Junior year

• A letter supporting 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.

• A letter of reference from a current or former non-social work professor or employer.

• 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 a Professional Program. 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.

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 Dr. Jay Memmott, Chair of the Department of Social Work. Jay.Memmott@usd.edu
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 limit your personal statement to no more than two double spaced typewritten pages (approximately 500 words). The accuracy and quality of writing in this statement will be evaluated as evidence of the candidate's potential for professional written communication.

1. Discuss your reasons for wishing to enter or continue in the field of Social Work. Discuss factors and, or experiences you believe will be helpful to you as a student in Social Work. Areas of:
   a. Employment, and Volunteer service
   b. Education and Special interests
   c. Family and Cultural experiences
   d. Personal experiences with diverse groups

2. Discuss your understanding of professional social work values and how those values are congruent with your own values.

3. Comment on your strengths and areas in which you wish to grow academically and professionally. Include an assessment of your communication skills (verbal, listening, and writing) in this discussion.

4. Indicate your career interests and your present ideas about job possibilities and the satisfaction and challenges you expect to find in a Social Work career.

5. Discuss your experiences working with diverse community members or addressing issues of social justice.

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
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: ___________________________  ___________________________

(Printed Clearly)  SIGNATURE

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: ___________________________  ___________________________

(Printed Clearly)  SIGNATURE

DATE: __________________________
Volunteer or Paid Experience

Verification of 60 hours or more

In a Helping Service Field

In the verification of volunteer or paid experience document 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.

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

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. __________/______/______
      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_______
   (if neg. see immunization policy) Updated 8/7/2018
REQUIRED IMMUNIZATION FORM – PAGE 2 of 2

Name DOB USD ID#

E. **Tuberculos is 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

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 Nov. 1st annually Date: ______/_____/_____

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

**RECOMMENDED IMMUNIZATIONS:**

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

Vaccine: _______________ Date: ______/_____/_____

Vaccine: _______________ Date: ______/_____/_____

H. **Childhood DPT/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 8/7/2018
University of South Dakota Health Affairs
ANNUAL SYMPTOM CHECKLIST FOR TUBERCULOSIS

This form is to be used annually when a student has had a positive result occur from Tuberculosis screening using either skin testing (PPD) or blood sample (QFT-G).

Student’s Name: ___________________________ Date: __________________

In the last year have you experienced any of the following symptoms for more than three weeks at a time?

<table>
<thead>
<tr>
<th>SIGN &amp; SYMPTOM REVIEW:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive sweating at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing up blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive fatigue</td>
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<td></td>
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<tr>
<td>Persistent fever</td>
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</tbody>
</table>

TB skin test: Date__________ Reading (mm)______________

Quantiferon: Date__________ Results____________________

Date of last chest x-ray______________

Chest x-ray results__________________________

Prophylactic treatment received? If yes; drug, dosage, and duration of treatment.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Student’s Signature ___________________________ Date ____________

Nurse’s Signature ___________________________ Date ____________