



#CAPSM APPLICATION



#CAPSM Program Student Application Form

Applicant Information

NAME: _____
 Last Name First Name Middle Initial

ADDRESS: _____
 Street City State ZIP

PHONE/
 EMAIL: _____
 Phone Number Cell Number Email

Date of Birth (MM/DD/YY): _____ Gender: ☐ Male ☐ Female

Grade Level: ☐ 11th (Junior) ☐ 12th (Senior)

HIGH SCHOOL
 NAME: _____
 Last Name First Name Middle Initial

HIGH SCHOOL
 ADDRESS: _____
 Street City State ZIP

Current GPA (if applicable) Cumulative GPA: _____

CAREER INTERESTS (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Agriculture, Food Processing & Natural Resources | <input type="checkbox"/> Hospitality & Tourism |
| <input type="checkbox"/> Architecture, Industrial Design, CAD | <input type="checkbox"/> Human Services (e.g., Social Work, Psychology, Counseling) |
| <input type="checkbox"/> Audio/Visual Technology Management & Administration | <input type="checkbox"/> Information Technology, Computer Science |
| <input type="checkbox"/> Business Management, Process Management, Human Resources | <input type="checkbox"/> Law |
| <input type="checkbox"/> Business Office Administration/Support Services | <input type="checkbox"/> Marketing, Advertising, Promotion |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Military Services (e.g., Army, Marines, Navy, or Reserves) |
| <input type="checkbox"/> Education, Training, Library Science | <input type="checkbox"/> Performing & Fine Arts, Graphic Design, Fashion Design |
| <input type="checkbox"/> Engineering, Mathematics, Research/Science (STEM) | <input type="checkbox"/> Public Safety, Corrections & Security |
| <input type="checkbox"/> Finance, Banking, Accounting | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Government, Public Administration, Planning, Transportation, Distribution & Logistics | <input type="checkbox"/> Vocational: (e.g., Automotive, Cosmetology, Construction, Industrial Trades, Technician) |
| <input type="checkbox"/> Health Science (Medicine, Dentistry, Nursing, Pharmacy) | <input type="checkbox"/> Other: _____ |

Parental/Legal Guardian Information

NAME: _____
 Last Name First Name Middle Initial

ADDRESS: _____
 Street City State ZIP

PHONE/
 EMAIL: _____
 Phone Number Cell Number Email

Emergency Contacts

NAME: _____
 Last Name First Name Last Name First Name

PHONE/
 EMAIL: _____
 Phone Number Email Phone Number Email