

ACADEMIC REFERENCE

As a candidate for admission to St. Louis College of Pharmacy, you are required to submit this reference to supplement your admissions file. Please complete the indicated portion of the form and submit to your high school guidance counselor for completion.

TO BE COMPLETED BY THE APPLICANT

NAME:

LAST

FIRST

MIDDLE

ADDRESS:

ADDRESS LINE 1

ADDRESS LINE 2

CITY

STATE

ZIP

SIGNATURE:

I understand that this form will become a part of my permanent record.

APPLICANT NAME (PRINT)

APPLICANT SIGNATURE

DATE

After completing this portion of the reference, submit the form to your guidance counselor for completion. Your counselor may return the form directly to:

Office of Admissions
St. Louis College of Pharmacy
4588 Parkview Place
St. Louis, MO 63110-1088

