LSU Health
NEW ORLEANS
School of Public Health

FULL NAME: _____

SOCIAL SECURITY NUMBER:_____

BY SIGNING THIS FORM, I GIVE PERMISSION TO THE ADMISSIONS OFFICES TO RELEASE MY FULL APPLICATION RECORDS TO THE LSUHSC SCHOOL OF PUBLIC HEALTH INCLUDING ANY TRANSCRIPTS. INFORMATION FROM THESE RECORDS WILL BE USED FOR THE SOLE PURPOSE OF DETERMINING MY ELIGIBILITY FOR ADMISSION TO THE MASTER OF PUBLIC HEALTH DEGREE PROGRAM.

SIGNATURE TO PERMIT RELEASE: _____

DATE SIGNED: _____

RETURN THIS DOCUMENT TO:
ISABEL BILLIOT
ADMISSIONS AND STUDENT AFFAIRS
LSUHSC SCHOOL OF PUBLIC HEALTH
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IBILLI@LSUHSC.EDU 504.568.5773