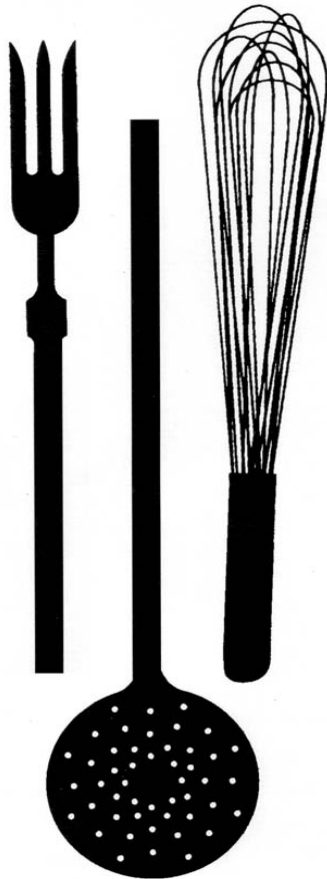


# Delaware Technical & Community College

Stanton/Wilmington Campus



## Culinary Arts Admission Application Packet

The Culinary Arts Degree is offered as a full-time or part-time day program with limited enrollment. Please remember early admission starts in April for the Fall semester and early admission for the Spring semester starts in October.

Delaware Technical & Community College welcomes all applicants, and we are committed to helping you find the program that will bring you closer to your goals. All programs may not be appropriate for all students, however, and some curricula, such as Culinary Arts, have selective admission criteria.

Please read the admission policy carefully and contact us with any questions or concerns you may have. Congratulations on taking the first step toward your career in Culinary Arts!

**DELAWARE  
TECH** 

**THE ASSOCIATE DEGREE CULINARY ARTS DEPARTMENT RESERVES THE RIGHT TO CHANGE THE ADMISSION CRITERIA YEARLY.**



Accredited by American Culinary Federation Accreditation Commission, January 2006

DELAWARE TECHNICAL & COMMUNITY COLLEGE  
ASSOCIATE DEGREE CULINARY ARTS PROGRAM

**ADMISSION POLICY**

**Admission process to the College and the Culinary Arts Program:**

1. Apply to the college declaring **Culinary Arts** as your major.
2. Take the required college Placement test, unless you can prove completion of college-level math, reading and English composition with a "C" grade or better with an official college transcript, or have SAT or ACT scores.
3. Make an appointment to complete the admissions process with an admissions counselor.
4. Make an appointment with the Culinary Arts counselor to discuss, complete and submit the **separate Culinary Arts application** to the Admissions office.
5. Upon review and approval of the Culinary Arts application, you will be contacted by a department representative to sign up for appropriate classes. Chef David Nolker, Department Chair, or Chef Instructors Ron Leounes and/or Thom Howell, or our counselor for the program, Susan Stoller, will contact you.

Students who wish to be admitted to the Associate Degree Culinary Arts Program must have **all** of the following documentation on file in the Admissions Office **as soon as possible**. Completed files will be reviewed weekly. We will continue to review applications until the class is full. Applications received after the class is full will be considered for the following year, unless an opening occurs.

Items 1 thru 7 are required for consideration of acceptance into the program.

1. High School Transcript or G.E.D
2. ACT, or SAT Scores or Accuplacer  
Mathematics Scores  
Reading Scores  
Writing Scores
3. Contact Information
4. Statement of Interest
5. Employment History Form
6. Physical Examination (This examination must include a test for tuberculosis.)
7. Health Insurance

When applicable the following documentation should also be provided:

8. Culinary Certificate
9. Culinary Seminars/Workshops/CEU's
10. Letter of Reference

Specific requirements concerning the above documentation will be explained by the Admissions Office at the time the application is submitted.

**Students selected for admission into the Culinary Arts Program will be notified as soon as possible after the review of their documentation and scheduled for an information session to arrange a schedule of courses.**

**CONTACT INFORMATION**

**CULINARY PROGRAM**

Name:

Address:

Phone (H) (     )     -

(W) (     )     -

E-Mail:

Optional E-Mail:

Date of Application:     /     /

Student ID#     -     -

Date of Birth:     /     /

Delaware Resident:  Yes  No

Previous DTCC enrollment location:

Stanton  Wilmington  Owens  Terry

Previous College(s):

1.

2.

3.

I hereby apply for the Culinary Arts Program. I have received a copy of the Culinary Arts Admission Policy and will comply with all of the requirements.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**FOR OFFICE USE ONLY**

Please initial documents in file:	
1. _____ High School Transcript/G.E.D	7. _____ Culinary Certificate
2. _____ Physical Examination- <b>must be completed by examining Physician</b>	8. _____ Culinary Seminars/Workshops/CEU's
3. _____ Employment History Form	9. _____ Letter of Reference
4. _____ Statement of Interest	
5. _____ CPT Scores	
Mathematics Scores _____	
Reading Scores _____	
Writing Scores _____	
6. _____ Health Insurance	

## **STATEMENT OF INTEREST**

Please write a short paragraph for each of the following:

1. Why are you interested in a Culinary Arts career?

2. What are your goals after graduation?

3. What are your expectations of the program?

4. Describe your previous food handling experiences, either at home or work.

## EMPLOYMENT HISTORY

<i>Employment (List most recent first)</i>		<i>If more space is required, attach additional page.</i>	
<b>Employer</b>	<b>Telephone Number</b> (    )    -	<b>Dates Employed</b>	
		<b>From</b>	<b>To</b>
		<b>Month/Year</b>	<b>Month/Year</b>
<b>Address</b>	<b>Position Held</b>	/	/
<b>Reason for Leaving</b>	<b>Supervisor's Name</b>	<b>Hourly/Annual Salary</b>	
		<b>Starting</b>	<b>Final</b>
<b>Work Performed</b>		\$	\$
		<b>Full-Time</b>	<b>Part-Time</b>
		<input type="checkbox"/>	<input type="checkbox"/>
<b>Employer</b>	<b>Telephone Number</b> (    )    -	<b>Dates Employed</b>	
		<b>From</b>	<b>To</b>
		<b>Month/Year</b>	<b>Month/Year</b>
<b>Address</b>	<b>Position Held</b>	/	/
<b>Reason for Leaving</b>	<b>Supervisor's Name</b>	<b>Hourly/Annual Salary</b>	
		<b>Starting</b>	<b>Final</b>
<b>Work Performed</b>		\$	\$
		<b>Full-Time</b>	<b>Part-Time</b>
		<input type="checkbox"/>	<input type="checkbox"/>
<b>Employer</b>	<b>Telephone Number</b> (    )    -	<b>Dates Employed</b>	
		<b>From</b>	<b>To</b>
		<b>Month/Year</b>	<b>Month/Year</b>
<b>Address</b>	<b>Position Held</b>	/	/
<b>Reason for Leaving</b>	<b>Supervisor's Name</b>	<b>Hourly/Annual Salary</b>	
		<b>Starting</b>	<b>Final</b>
<b>Work Performed</b>		\$	\$
		<b>Full-Time</b>	<b>Part-Time</b>
		<input type="checkbox"/>	<input type="checkbox"/>
<b>Employer</b>	<b>Telephone Number</b> (    )    -	<b>Dates Employed</b>	
		<b>From</b>	<b>To</b>
		<b>Month/Year</b>	<b>Month/Year</b>
<b>Address</b>	<b>Position Held</b>	/	/
<b>Reason for Leaving</b>	<b>Supervisor's Name</b>	<b>Hourly/Annual Salary</b>	
		<b>Starting</b>	<b>Final</b>
<b>Work Performed</b>		\$	\$
		<b>Full-Time</b>	<b>Part-Time</b>
		<input type="checkbox"/>	<input type="checkbox"/>

**DELAWARE TECHNICAL & COMMUNITY COLLEGE  
REPORT OF MEDICAL HISTORY**

Stanton       Wilmington  
 Male         Female

Social Security Number \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address (Number and Street) \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth \_\_\_\_\_

( ) ( )  
Home Telephone Number \_\_\_\_\_ Work Telephone Number \_\_\_\_\_

**PERSONAL HISTORY. PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on additional sheet.**

HAVE YOU HAD?	YES	NO		YES	NO		YES	NO
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Anxiety/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Disease or Injury of Joints (including Fracture or Dislocation)	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Depression	<input type="checkbox"/>	<input type="checkbox"/>	Trick Knee, Shoulder, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Eye, Ear, Nose, Throat Problem	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury without Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Hernia (Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Tumor/Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Recent Gain/Loss of Weight (at least 10 lbs)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heat or Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, Fainting, Passing Out	<input type="checkbox"/>	<input type="checkbox"/>
<b>ALLERGY TO:</b>	<input type="checkbox"/>	<input type="checkbox"/>	Easy Fatigue (tiredness)	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Glasses/Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Pressure in Chest	<input type="checkbox"/>	<input type="checkbox"/>	Difficult or Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Bee Stings	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough/Trouble Breathing	<input type="checkbox"/>	<input type="checkbox"/>	HIV Test	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations (Skipping Beats)	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Hay Fever, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever or Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>			

**COMMENTS:** \_\_\_\_\_

	NO	YES	EXPLAIN
A. Has your physical activity been restricted during the past five years? If yes, give reasons and durations.	<input type="checkbox"/>	<input type="checkbox"/>	
B. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem. If yes, give details.	<input type="checkbox"/>	<input type="checkbox"/>	
C. Have you had any illness or injury in the last five years, other than already noted? If yes, give details.	<input type="checkbox"/>	<input type="checkbox"/>	
D. Have you ever been hospitalized? If yes, list reason(s) and date(s).	<input type="checkbox"/>	<input type="checkbox"/>	
E. Have you been taking any medication for more that two months. If yes, list names of medications(s).	<input type="checkbox"/>	<input type="checkbox"/>	
F. Are you currently under a doctor's care for any disease/disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
G. Do you need any special assistance or accommodation?	<input type="checkbox"/>	<input type="checkbox"/>	
H. First Menses, age _____ Date of last period _____ Frequency of menses _____			
I. For Athletes: Any previous sports restrictions? If yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>	
Need for special equipment (such as braces or mouth guard)? If yes, list equipment.	<input type="checkbox"/>	<input type="checkbox"/>	
Loose teeth/Dental problem? If yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>	
Family History: Sudden death before age 50, heart disease, etc.	<input type="checkbox"/>	<input type="checkbox"/>	

**PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY.**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF EXAMINING PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

**PHYSICIANS REPORT OF HEALTH STATUS**

To the Examining Physician: Please review the student's medial history (reverse side) and complete this form. Please comment on all positive answers.

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

**IMMUNIZATION RECORD**

Disease	Date of Disease	Dates of Immunization			Results of Lab Test (Attach copy) If applicable
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	
Measles					
Mumps					
Rubella					
MMR					
Tetanus					
Hepatitis-B					

**CORRECTED VISION**

**URINALYSIS**

**PPD(TINE TEST NOT ACCEPTED)**

Right 20/  
Left 20/  
Contacts  
Glasses

Temp \_\_\_\_\_ Leu \_\_\_\_\_ Nit \_\_\_\_\_  
Pulse \_\_\_\_\_ Pro \_\_\_\_\_ pH \_\_\_\_\_  
Resp. \_\_\_\_\_ Bld \_\_\_\_\_ SG \_\_\_\_\_  
BP \_\_\_\_\_ Ket \_\_\_\_\_ Glu \_\_\_\_\_  
Ht. \_\_\_\_\_  
Wt. \_\_\_\_\_

Date Given \_\_\_\_\_ Date Read \_\_\_\_\_  
Results: Pos. \_\_\_\_\_ Neg. \_\_\_\_\_  
Chest X-Ray Required with Positive PPD.  
X-Ray results (Please attach copy)  
Date: \_\_\_\_\_ Pos. \_\_\_\_\_ Neg. \_\_\_\_\_  
Nursing students: PPD NOT Required at time of Admission.

**Are there abnormalities in the following systems? Describe any abnormalities in detail.**

**NO YES EXPLAIN**

	NO	YES	EXPLAIN
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genital/Urinary			
Hernia			
Lymph Nodes			
Muscular/Skeletal			
Metabolic/Endocrine			
Neurological			
Psychiatric			
Skin			

**NO YES EXPLAIN**

Is there loss or seriously impaired function of any organ?			
Do you have any recommendations for any physical restrictions?			
Do you have any recommendations regarding the care of this student?			
Is the patient now under treatment for any medical or emotional condition?			

**On the basis of history and examination, this student will be able to participate in: (PLEASE CHECK ONE)**

Sports:  
 Soccer     Volleyball     Basketball     Softball

Technology:  
 Nursing     Allied Health     Culinary Arts     Criminal Justice Practicum     Exercise Science     Other \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PRINT LAST NAME \_\_\_\_\_ DATE \_\_\_\_\_

**Return To:**

Delaware Technical & Community College  
David Nolker

Stanton Campus  
400 Stanton-Christiana Road  
Newark, DE 19713