



Selective Health Programs Appointment Request

Name: _____

WCC/VCCS Student ID Number: _____

Email Address: _____

Phone Number: _____ Cell/Text Number: _____

Test Date: (select one)

Tuesday, September 4	Thursday, October 25	Friday, January 11	Tuesday, February 5
Thursday, September 6	Thursday, November 1	Tuesday, January 15	Thursday, February 7
Friday, September 21	Friday, November 2	Wednesday, January 16	Friday, February 8
Tuesday, September 25	Tuesday, November 6	Friday, January 18	Tuesday, February 12
Thursday, September 27	Thursday, November 8	Tuesday, January 22	Wednesday, February 13
Friday, October 5	Friday, November 16	Thursday, January 24	Thursday, February 14
Tuesday, October 9	Tuesday, November 27	Friday, January 25	Friday, February 15
Thursday, October 11	Friday, November 30	Tuesday, January 29	
Friday, October 19	Tuesday, December 4	Thursday, January 31	
Tuesday, October 23	Thursday, December 6	Friday, February 1	

Preferred Testing Location:

WCC Main Campus Crossroads Institute (Galax) VHCC (Abingdon) SWCC (Cedar Bluff)

Test Time (please circle)

9:00 a.m. 1:00 p.m.

How many times have you taken this test? (please circle)

First Retake 1 Retake 2 Retake 3 Retake 4 Retake 5

Program(s) you are applying to (select all that apply)

Nursing Dental Hygiene Physical Therapist Assistant Medical Lab Technology

Which School are you applying to:

If you have any questions or concerns, please call 276-223-4758 or email testing@wcc.vccs.edu