INSTRUCTIONS TO APPLICANTS (TO ASSIST IN APPLYING FOR ADMISSION)

1. Application must be submitted to HCOP@UCHC.EDU no later than midnight April 1.
2. Applications are considered by the Admissions Committee when they are complete. Applicants should understand that it is their responsibility to submit all material, including recommendation letters.
3. After receipt and review of applications, the Admissions Committee will contact the prospective program participant. Priority consideration will be given to Pipeline Participants.

APPLICATIONS CONSIST OF THE FOLLOWING

1. A completed application for admission with essay
2. Official school transcript(s) – academic school years (high school or college/university)
3. Score reports for SAT and ACT if available
4. Two (2) recommendations (preferably from a science instructor)
5. A copy of the latest Federal Income Tax Form 1040 or equivalent on which you are claimed as a dependent (submit 1040 form when completed and filed)

TO BE COMPLETED BY STUDENT APPLICANT

Are you a Minority Access to Research Careers (MARC) Student: □ Yes □ No

Have you participated in any programs at UConn Health in previous years including Great Explorations Program, Jumpstart Program, Junior Doctors Academy, Senior Doctors Academy, Sport & Medical Sciences Academy Epidemiology Course, Sport & Medical Science Academy College Science Series, or High School Mini Medical/Dental School Program?

If yes, indicate the program(s) in which you have participated and the year(s):

Have you been accepted to any other summer programs? : □ Yes □ No

Career Interest: select one drop down □ Medicine □ Dental Medicine □ Biomedical Research/PhD □ Nursing □ Pharmacy □

□ Allied Health (specify) __________________________ □ Other (specify) __________________________
# PERSONAL INFORMATION
(PLEASE TYPE OR PRINT CLEARLY)
(ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED COMPLETELY)

## 1. NAME:
- **FIRST NAME**
- **MIDDLE NAME**
- **LAST NAME**

- **DATE OF BIRTH:**
- **AGE:**
- **SOCIAL SECURITY NUMBER:**

- **CITY AND STATE OF BIRTH:**

- **CITIZENSHIP:**
  - [ ] USA
  - [ ] PERMANENT RESIDENT
  - [ ] OTHER (SPECIFY)

## 2. LEGAL RESIDENCE:
- **STREET/APARTMENT/PO BOX**
- **CITY**
- **STATE**
- **ZIP CODE**

- **AREA CODE/TELEPHONE NUMBER**
- **CELL PHONE NUMBER**

## 3. E-MAIL ADDRESS (MOST FREQUENTLY USED AND CHECKED)

## 4. LAST DAY OF ACADEMIC YEAR AND/OR LIVING ON CAMPUS FOR ACADEMIC YEAR:

# FAMILY INFORMATION
(ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED COMPLETELY)

- **GENDER:** SELECT ONE
- **ETHNICITY:** SELECT ONE

- **FAMILY TAXABLE INCOME:**
- **FAMILY SIZE (TOTAL NUMBER OF EXEMPTIONS CLAIMED):**

  (INFO PER FEDERAL FORM 1040 OR EQUIVALENT ON WHICH YOU ARE CLAIMED)

- **FATHER’S NAME:**
- **OCCUPATION:**
- **EDUCATION:** SELECT ONE
  - [ ] LESS THAN/PARTIAL HIGH SCHOOL
  - [ ] HIGH SCHOOL GRADUATE
  - [ ] SOME COLLEGE
  - [ ] ASSOCIATES DEGREE

- **MOTHER’S NAME:**
- **OCCUPATION:**
- **EDUCATION:** SELECT ONE
  - [ ] LESS THAN/PARTIAL HIGH SCHOOL
  - [ ] HIGH SCHOOL GRADUATE
  - [ ] SOME COLLEGE
  - [ ] ASSOCIATES DEGREE

A COPY OF THE LATEST FEDERAL INCOME TAX FORM 1040 OR EQUIVALENT ON WHICH YOU ARE CLAIMED AS A DEPENDENT IS REQUIRED

(SUBMIT 1040 FORM WHEN COMPLETED AND FILED)

# LIST IN CHRONOLOGICAL ORDER ALL SCHOOLS YOU HAVE ATTENDED

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INDICATE SCHOOL CURRENTLY ATTENDING AND PRESENT GRADE:

- **GPA:**
- **SCIENCE GPA:**

# TEST SCORES:

- **SAT:**
  - **TOTAL:**
  - **CRITICAL READING:**
  - **MATHEMATICS:**
  - **WRITING SKILLS:**

- **ACT:**
  - **COMPOSITE SCORE:**
  - **ENGLISH:**
  - **MATH:**
  - **SCIENCE:**
  - **WRITING:**
LIST HONORS RECEIVED (INCLUDING HONOR SOCIETIES)


LIST EXTRACURRICULAR AND COMMUNITY ACTIVITIES


LIST ANY RESEARCH EXPERIENCE


EMPLOYMENT EXPERIENCE: (FULL/PART TIME)

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HAVE YOU HAD COMPUTER TRAINING: SELECT ONE

LIST SCIENCE AND MATHEMATICS COURSES YOU EXPECT TO COMPLETE THIS SCHOOL YEAR:

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PERMISSION FOR STUDENT TO PARTICIPATE IN
THE HEALTH PROFESSIONS PARTNERSHIP INITIATIVE
SUMMER ENRICHMENT PROGRAMS

I HEREBY CONSENT/GIVE MY PERMISSION TO PARTICIPATE IN THE HEALTH PROFESSIONS PARTNERSHIP INITIATIVE PROGRAMS. I UNDERSTAND THAT PARTICIPATION INCLUDES ATTENDANCE AT ALL SESSIONS OF THE REQUIRED ACTIVITIES OUTLINED IN PROGRAM DESCRIPTIONS AND I FURTHER UNDERSTAND THAT THERE WILL ALSO BE PARTICIPATION IN FIELD TRIPS AND OTHER ACTIVITIES AWAY FROM THE SITE. I WILL/GIVE PERMISSION TO ATTEND THESE FUNCTIONS AND TO BE TRANSPORTED BY APPROVED BUSES UNLESS I GIVE WRITTEN WITHDRAWAL OF PERMISSION FOR A SPECIFIC EVENT. THE DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS IS GIVEN PERMISSION TO REPRODUCE FOR PUBLICATIONS AND INTERNET USE ANY PHOTOS TAKEN AT PROGRAM FUNCTIONS.

APPLICANT SIGNATURE_________________________________________________DATE________

PARENT/GUARDIAN SIGNATURE_____________________________________________DATE________

(PLEASE SIGN IF YOU ARE A PARENT OR GUARDIAN OF AN APPLICANT UNDER EIGHTEEN YEARS OF AGE)

FEDERAL FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

I HEREBY CONSENT TO THE DISCLOSURE OF STUDENT INFORMATION RECORDS MAINTAINED BY THE DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS AND/OR THE PUBLIC SCHOOLS. THIS INFORMATION WILL BE MAINTAINED IN A CONFIDENTIAL MANNER AND WILL BE USED ONLY FOR THE PURPOSES OF THE HCOP EVALUATION. USE IS CONSISTENT WITH THE FEDERAL FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, OR OTHER STATE OR FEDERAL LAWS, REGULATIONS, OR POLICIES. I UNDERSTAND THAT THIS PERMISSION MAY BE WITHDRAWN AT ANY TIME. THE DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS IS GIVEN PERMISSION TO REPRODUCE FOR PUBLICATIONS AND INTERNET USE ANY PHOTOS TAKEN OF MYSELF OR MY CHILD AT PROGRAM FUNCTIONS.

APPLICANT SIGNATURE_________________________________________________DATE________

PARENT/GUARDIAN SIGNATURE_____________________________________________DATE________

(PLEASE SIGN IF YOU ARE A PARENT OR GUARDIAN OF AN APPLICANT UNDER EIGHTEEN YEARS OF AGE)
ESSAY: TYPE OR WRITE (LEGIBLY) IN THE SPACE BELOW AN ESSAY DESCRIBING YOUR BACKGROUND, GOALS, MOTIVATION, HEALTH CAREER INTERESTS, AND REASONS FOR WANTING TO PARTICIPATE IN THIS PROGRAM. IF NECESSARY, EXPLAIN ANY UNUSUAL ASPECTS OF YOUR PREPARATION AND/OR APPLICATION (USE ADDITIONAL SHEET(S) WITH NAME AND SOCIAL SECURITY NUMBER IF NECESSARY).

I CERTIFY THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

______________________________  __________________________
SIGNATURE                      DATE

APPLICATION DEADLINE IS APRIL 1

PLEASE RETURN TO:
DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS
UCONN HEALTH
FARMINGTON, CONNECTICUT 06030-3920
ATTENTION: TRACEY HIGGINS
860-679-8031
HIGGINS@UCHC.EDU
WEBSITE: HEALTH.UCONN.EDU/HCOP/