First Name | Middle Name | Last Name | School

UCONN HEALTH

Department of Health Career Opportunity Programs
Aetna Health Professions Partnership Initiative
High School Student Research Apprentice
Summer Enrichment Programs

Website: www.hcop.uchc.edu

Sponsored By:
Health Career Opportunity Programs
UConn Health
Farmington, Connecticut 06030-3920

Instructions to Applicants (to assist in applying for admission)

1. Application must be submitted to HCOP@UCHC.EDU no later than midnight April 1st.
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.

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)

For office use only	
Date received	Computer entry

To be completed by student applicant

Are you a Minority Access to Research Careers (MARC) Student: Select One

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

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

Career interest:

Select One

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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 (must be a US citizen or permanent resident to participate):

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 school for academic year:** _____

Family Information (all questions in this section must be answered completely)

Gender: Select One

Ethnicity: Select One

Family Income Level (Adjusted Gross Income): _____ **Family Size (Total Number of Exemptions Claimed):** _____
(Info Per Federal Form 1040 or Equivalent you are claimed as a dependent)

Father:

Name: _____ **Occupation:** _____

Education: Select One Father's Marital Status

Mother:

Name: _____ **Occupation:** _____

Education: Select One Mother's Marital Status

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

Institution	City	Dates Attended

Indicate school currently attending and present grade: _____

GPA: _____ **Science GPA:** _____

Test Scores:

SAT: **Total** _____ **Critical Reading** _____ **Mathematics** _____ **Writing Skills** _____

ACT: **Composite Score** _____ **English** _____ **Math** _____ **Reading** _____ **Science** _____ **Writing** _____

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List honors received (including honor societies)

List extracurricular and community activities

List any research experience

Employment experience: (full/part time)

Employer **Length of Employment**

Have you had computer training: Select One

List science and mathematics courses you expect to complete this school year:

FALL SEMESTER		**SPRING SEMESTER**	
Course Title	**Course Credit**	**Course Title**	**Course Credit**

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

I hereby consent/give my permission to participate in the Aetna 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)

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ESSAY: TYPE 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**

BY TYPING YOUR NAME ABOVE YOU ARE AUTHORIZING THIS TO BE AS BINDING AS YOUR SIGNATURE.

UPON COMPLETION OF YOUR APPLICATION PLEASE USE THE *SUBMIT FORM* BUTTON ABOVE TO APPLY TO THE PROGRAM.

APPLICATION DEADLINE IS APRIL 1ST

PLEASE SEND SUPPLEMENTAL MATERIALS TO:
DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS
UCONN HEALTH
FARMINGTON, CONNECTICUT 06030 – 3920
ATTENTION: TRACEY HIGGINS
(860)679-8031
HIGGINS@UCHC.EDU

WEBSITE: HCOP.UCHC.EDU