

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:

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?

IF YES, INDICATE THE PROGRAM(S) IN WHICH YOU HAVE PARTICIPATED AND THE YEAR(S):

CAREER INTEREST:

FIRST NAME MIDDLE NAME LAST NAME SCHOOL

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:
ETHNICITY:
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:
MOTHER:
NAME: OCCUPATION:
EDUCATION:

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

Table with 3 columns: 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)

<u>EMPLOYER</u>	<u>LENGTH OF EMPLOYMENT</u>
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HAVE YOU HAD COMPUTER TRAINING:

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

<u>COURSE TITLE</u>	<u>FALL SEMESTER</u>	<u>COURSE CREDIT</u>	<u>COURSE TITLE</u>	<u>SPRING SEMESTER</u>	<u>COURSE CREDIT</u>
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**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: Anastasia Rollins
(860) 679-3484
rollins@uch.edu

WEBSITE: HCOP.UCHC.EDU