

FIRST NAME

MIDDLE NAME

LAST NAME

COLLEGE ATTENDING

# UConn HEALTH

## AETNA HEALTH PROFESSIONS PARTNERSHIP INITIATIVE

### PRE COLLEGE ACADEMIC ENRICHMENT PROGRAM

WEBSITE: [HEALTH.UCONN.EDU/HCOP/](http://HEALTH.UCONN.EDU/HCOP/)

SPONSORED BY:

HEALTH CAREER OPPORTUNITY PROGRAMS

UConn HEALTH

FARMINGTON, CT 06030-3920

#### INSTRUCTIONS TO APPLICANTS (TO ASSIST IN APPLYING FOR ADMISSION)

1. APPLICATION MUST BE RECEIVED BY THE HCOP OFFICE NO LATER THAN MAY 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.

#### APPLICATIONS CONSIST OF THE FOLLOWING

1. A COMPLETED APPLICATION FOR ADMISSION WITH ESSAY
2. OFFICIAL SCHOOL TRANSCRIPT(S) – ALL ACADEMIC SCHOOL YEARS
3. TWO (2) RECOMMENDATIONS (PREFERABLY FROM A SCIENCE INSTRUCTOR)
4. OFFICIAL COPY OF YOUR SAT AND/OR ACT SCORE REPORT
5. A COPY OF THE LATEST FEDERAL INCOME TAX FORM 1040 OR EQUIVALENT ON WHICH YOU ARE CLAIMED AS A DEPENDENT (SUBMIT WHEN COMPLETED AND FILED)

FOR OFFICE USE ONLY

DATE RECEIVED \_\_\_\_\_

COMPUTER ENTRY \_\_\_\_\_

For additional information, contact:

Kerry-Ann Stewart, Ph.D.  
 Health Career Opportunity Programs  
 UConn Health  
 263 Farmington Ave.  
 Farmington, CT 06030-3920  
 860-679-3926  
[hcop@uchc.edu](mailto:hcop@uchc.edu)

#### TO BE COMPLETED BY STUDENT APPLICANT

PLEASE CHECK THE PROGRAM TO WHICH YOU ARE APPLYING:

**PRE COLLEGE ACADEMIC ENRICHMENT PROGRAM** (SEE WEBSITE FOR DETAILS)

UConn, Storrs     CCSU

HAVE YOU PREVIOUSLY PARTICIPATED IN THE HEALTH CAREER DISCOVERY PROGRAM (CPEP), GREAT EXPLORATIONS PROGRAM, JUMPSTART PROGRAM, JUNIORS DOCTORS ACADEMY, SENIORS DOCTORS ACADEMY, SPORT & MEDICAL SCIENCES ACADEMY EPIDEMIOLOGY COURSE, SPORT & MEDICAL SCIENCES ACADEMY COLLEGE SCIENCE PARTNERSHIP SERIES, HIGH SCHOOL MINI MEDICAL/DENTAL SCHOOL PROGRAM OR HIGH SCHOOL STUDENT RESEARCH APPRENTICE PROGRAM?

Yes  No    IF YES, INDICATE THE PROGRAM(S) IN WHICH YOU HAVE PARTICIPATED AND THE YEAR(S):

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CAREER INTEREST:

MEDICINE     DENTAL MEDICINE     BIOMEDICAL RESEARCH/PhD     NURSING     PHARMACY     PUBLIC HEALTH  
 ALLIED HEALTH (SPECIFY) \_\_\_\_\_     OTHER (SPECIFY) \_\_\_\_\_

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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: 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 SCHOOL FOR ACADEMIC YEAR:

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

GENDER: MALE FEMALE
ETHNICITY: BLACK/AFRICAN AMERICAN CAUCASIAN NATIVE AMERICAN/ALASKAN MEXICAN AMERICAN/CHICANO PUERTO RICAN
ASIAN (SPECIFY) NATIVE HAWAIIAN/PACIFIC ISLANDER OTHER (SPECIFY)
FAMILY INCOME LEVEL (ADJUSTED GROSS INCOME): FAMILY SIZE (TOTAL NUMBER OF EXEMPTIONS CLAIMED):
(FINFO PER FEDERAL FORM 1040 OR EQUIVALENT YOU ARE CLAIMED AS A DEPENDENT)
FATHER: MARRIED SINGLE WIDOWED DIVORCED SEPARATED
NAME: OCCUPATION:
EDUCATION: LESS THAN/PARTIAL HIGH SCHOOL HIGH SCHOOL GRADUATE SOME COLLEGE ASSOCIATES DEGREE
BA/BS DEGREE GRADUATE SCHOOL PROFESSIONAL SCHOOL (SPECIFY)
MOTHER: MARRIED SINGLE WIDOWED DIVORCED SEPARATED
NAME: OCCUPATION:
EDUCATION: LESS THAN/PARTIAL HIGH SCHOOL HIGH SCHOOL GRADUATE SOME COLLEGE ASSOCIATES DEGREE
BA/BS DEGREE GRADUATE SCHOOL PROFESSIONAL SCHOOL (SPECIFY)
A COPY OF YOUR FEDERAL INCOME TAX FORM 1040 OR EQUIVALENT ON WHICH YOU ARE CLAIMED AS A DEPENDENT IS REQUIRED
(SUBMIT WHEN COMPLETED AND FILED)

LIST IN CHRONOLOGICAL ORDER ALL SCHOOLS YOU HAVE ATTENDED

Table with 3 columns: INSTITUTION, CITY, DATES ATTENDED

INDICATE HIGH SCHOOL CURRENTLY ATTENDING:
OVERALL GPA: SCIENCE GPA:

TEST SCORES: SAT: TOTAL CRITICAL READING MATHEMATICS WRITING SKILLS
ACT: COMPOSITE SCORE ENGLISH MATH READING SCIENCE WRITING
GRE: ANALYTICAL WRITING VERBAL QUANTITATIVE



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**FOR HIGH SCHOOL AND COLLEGE STUDENTS**

HAVE YOU EVER BEEN DISMISSED, DISQUALIFIED, SUSPENDED, ON PROBATION, OR SUBJECT TO DISCIPLINARY ACTION AT ANY HIGH SCHOOL OR COLLEGE/UNIVERSITY IN CONNECTION WITH YOUR ACADEMIC PERFORMANCE?  YES  NO

IF YES, ON A SEPARATE SHEET OF PAPER, EXPLAIN THE ACTION INCLUDING: 1) BRIEF DESCRIPTION OF INCIDENT 2) SPECIFIC CHARGE(S) 3) DISCIPLINARY ACTION TAKEN 4) HOW THE EXPERIENCE AFFECTED YOUR LIFE

HAVE YOU EVER BEEN DISMISSED, EXPELLED, VIOLATED AN HONOR CODE, DISQUALIFIED, SUSPENDED, ON PROBATION, OR SUBJECT TO DISCIPLINARY ACTION AT ANY HIGH SCHOOL OR COLLEGE/UNIVERSITY IN CONNECTION TO MISCONDUCT?  YES  NO

IF YES, ON A SEPARATE SHEET OF PAPER, EXPLAIN EACH VIOLATION INCLUDING: 1) BRIEF DESCRIPTION OF INCIDENT 2) SPECIFIC CHARGE(S) MADE 3) DISCIPLINARY ACTION TAKEN 4) HOW THE EXPERIENCE AFFECTED YOUR LIFE

**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 YOUR 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.

**APPLICATION DEADLINE IS MAY 1**

PLEASE RETURN TO:  
[HCOP@UCHC.EDU](mailto:HCOP@UCHC.EDU)

SUPPLEMENTAL MATERIALS SHOULD BE MAILED TO:  
DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS

UConn HEALTH  
FARMINGTON, CT 06030-3920  
ATTENTION: TRACEY HIGGINS  
860-679-8031

[HCOP@UCHC.EDU](mailto:HCOP@UCHC.EDU)

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