

# MEDICAL COMPREHENSION ASSESSMENT TEST PREP PROGRAM (MCAT)

Please print or type clearly using black or blue ink. **APPLICATION DEADLINE IS MARCH 20, 2015.**

## I. Contact Information

LAST NAME		FIRST NAME		MIDDLE NAME
PERMANENT ADDRESS				APT
CITY		STATE	ZIP	
CELL PHONE NUMBER ( )		E-MAIL ADDRESS		
LOCAL ADDRESS				APT
CITY		STATE	ZIP	
<b>PERSONS WHO WILL KNOW YOUR LOCATION IN TWO YEARS (I.E. RELATIVES, CLOSE FRIENDS, ETC.)</b>				
NAME		NAME		
ADDRESS		ADDRESS		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE	CELL PHONE	HOME PHONE	CELL PHONE	

## II. Demographic Information

DATE OF BIRTH / / 19__	PERMANENT RESIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		SOCIAL SECURITY NUMBER	
ETHNICITY	U.S. CITIZEN	GENDER	1 <sup>ST</sup> GENERATION COLLEGE STUDENT	RAISED IN A SINGLE-PARENT HOME
<input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> MULTI-ETHNIC	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>*an individual neither of whose natural or adoptive parents received a baccalaureate degree</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOW DID YOU FIND OUT ABOUT THIS PROGRAM? (CHECK ALL THAT APPLY)				
<input type="checkbox"/> POSTER/FLYER <input type="checkbox"/> RECRUITER/COUNSELOR <input type="checkbox"/> INFORMATION SESSION		<input type="checkbox"/> STUDENT/FRIEND <input type="checkbox"/> WEBSITE <input type="checkbox"/> MAGAZINE/NEWSPAPER		<input type="checkbox"/> OFFICE OF ACADEMIC ENHANCEMENT <input type="checkbox"/> OFFICE OF DIVERSITY & MULTICULTURAL AFFAIRS/ MILLER SCHOOL OF MEDICINE



UNIVERSITY OF MIAMI  
MILLER SCHOOL  
of MEDICINE



**Office of Diversity and Multicultural Affairs**  
 Rosenstiel Medical Science Building  
 1600 NW 10 Avenue, Suite 1130, Locator R11  
 Miami, Florida 33136  
 305-243-7156  
 305-243-7312  
[www.diversity.med.miami.edu](http://www.diversity.med.miami.edu)  
[www.miami.edu/mcatprogram](http://www.miami.edu/mcatprogram)

**Office of Academic Enhancement**  
 Pearson Residential College  
 5185 Ponce de Leon Blvd, Suite 144  
 Coral Gables, Florida 33146  
 305-284-3187  
 305-284-8155  
[www.miami.edu/oea](http://www.miami.edu/oea)

Attach a photo of yourself here  
 Please write your full name on the  
 back

Return application to Office of Diversity – MCAT Program, 1600 NW 10 Avenue, Suite 1130, Locator R11, Miami, Florida 33136

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## III. Family Information

COMBINED FAMILY INCOME <input type="checkbox"/> UNDER \$15K <input type="checkbox"/> \$15,001-25K <input type="checkbox"/> \$25,001-35K <input type="checkbox"/> \$35,001-50K <input type="checkbox"/> \$50,001-70K <input type="checkbox"/> \$70,001+	TOTAL NUMBER OF FAMILY MEMBERS
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<b>PRIMARY CARETAKER</b> (CHECK ONE) <input type="checkbox"/> FATHER <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> OTHER _____	
LAST NAME	FIRST NAME
CURRENT HOME ADDRESS	APT NUMBER
CITY, STATE	ZIP
HOME PHONE (    )	CELL PHONE (    )
OCCUPATION	SALARY
HIGHEST EDUCATION LEVEL COMPLETED <input type="checkbox"/> GRADE SCHOOL <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> TWO YEAR COLLEGE <input type="checkbox"/> VOCATIONAL OR TECHNICAL SCHOOL <input type="checkbox"/> BACHELOR DEGREE <input type="checkbox"/> MASTER'S DEGREE <input type="checkbox"/> DOCTORAL DEGREE	

<b>SECONDARY CARETAKER</b> (CHECK ONE) <input type="checkbox"/> MOTHER <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> OTHER _____	
LAST NAME	FIRST NAME
CURRENT HOME ADDRESS	APT NUMBER
CITY, STATE	ZIP
HOME PHONE (    )	CELL PHONE (    )
OCCUPATION	SALARY
HIGHEST EDUCATION LEVEL COMPLETED <input type="checkbox"/> GRADE SCHOOL <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> TWO YEAR COLLEGE <input type="checkbox"/> VOCATIONAL OR TECHNICAL SCHOOL <input type="checkbox"/> BACHELOR DEGREE <input type="checkbox"/> MASTER'S DEGREE <input type="checkbox"/> DOCTORAL DEGREE	

Are there any family circumstances or concerns that would be useful for us to know when evaluating your application? If so, please explain.

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*\*Please be as honest as possible when providing this information; its primary purpose is for grant writing. All information will be kept confidential and used solely for admissions and statistics.*

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## IV. Academic Information

Colleges/Universities attended. List most recent first.

Name of College/University	State	Major	Dates
1			-
2			-
3			-

Academic grading period:  Semester       Trimester       Quarterly

Class standing (by Credit) at time of application:  Junior       Senior       Post- Baccalaureate

Grade Point Average: (If you are unsure, consult your Registrar's Office for correct GPA calculation.)

Undergraduate: Science \_\_\_\_\_ Non-Science \_\_\_\_\_ Cumulative \_\_\_\_\_

Graduate: Science \_\_\_\_\_ Non-Science \_\_\_\_\_ Cumulative \_\_\_\_\_

Actual or Expected Date of Graduation: Undergraduate (Mo/Yr.): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Graduate (Mo/Yr.): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please provide data from your most recent test scores below:

SAT       YES      Year: \_\_\_\_\_      Critical Reading: \_\_\_\_\_      Mathematics: \_\_\_\_\_      Writing: \_\_\_\_\_  
 NO

ACT       YES      Year: \_\_\_\_\_      Composite Score: \_\_\_\_\_      Mathematics: \_\_\_\_\_      English: \_\_\_\_\_  
 NO      Reasoning Writing: \_\_\_\_\_      Reading: \_\_\_\_\_      Science: \_\_\_\_\_

MCAT       YES      Year: \_\_\_\_\_      Physical Sciences: \_\_\_\_\_      Biological Sciences: \_\_\_\_\_  
 NO      Verbal Reasoning: \_\_\_\_\_      Trial Section: \_\_\_\_\_

Will you be applying to enter a health professions school in the fall?  Yes  No

Have you participated in any academic summer program(s)?  Yes  No

Program Name	School/Institution	City, State	Dates
1			-
2			-
3			-

Have you applied to any other academic summer program(s)?  Yes  No

Program Name	School/Institution	City, State	Dates
1			-
2			-
3			-

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Please describe any pertinent hospital or medical field experience you have.

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List the principal extracurricular and community activities you are/were involved in during college:

Activity/Program Name	City, State	Dates	# of hrs
1			
2			
3			

Please provide the contact information for the three college professors writing your letters of recommendation.

Name:	Position:
Email Address:	Phone:
Name:	Position:
Email Address:	Phone:
Name:	Position:
Email Address:	Phone:

**Please attach a personal statement explaining why you wish to participate in this program and highlight any personal attributes that would be deemed desirable for medical school applicants. (Minimum of 400 words)**

Your completed application packet must contain:

- |   |   |
|---|---|
| <input type="checkbox"/> Completed Application Form<br><input type="checkbox"/> Official Transcript(s)<br><input type="checkbox"/> Three (3) letters of recommendation two (2) must be from college professors<br><input type="checkbox"/> Proof of Health Insurance (Required) | <input type="checkbox"/> Dean of Students Recommendation Form<br><input type="checkbox"/> Personal Statement (400 words minimum)<br><input type="checkbox"/> Wallet-Size Photo<br><input type="checkbox"/> Color Copy of Social Security Card (SSN) |
|---|---|

My signature below indicates: (1) that all the information contained in my application is complete, factually correct, and honestly presented; (2) that if I am accepted to this program, I agree to abide by the University of Miami Honor Code, a document which prohibits dishonesty in all academic work; (3) that I am submitting a complete application packet and that all documents listed above are included.

**I understand that incomplete and late applications will not be reviewed.**

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Signature	Printed Name	Date
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## V. Dean of Students Recommendation

**Applicant:** This form is confirmation of your good academic and disciplinary standing. Please complete Section I and ask the Dean of Students or similar official at your current or the most recent institution you have attended to complete Section II. This form may be returned with your application in a sealed envelope with the Dean's signature over the closure. Or, the Dean may send it to the address below. **APPLICATION DEADLINE IS MARCH 20, 2015**

Office of Diversity – MCAT Program,  
1600 NW 10 Avenue, Suite 1130, Locator R11  
Miami, Florida 33136

**Section I:** Should be completed by applicant.

LAST NAME	FIRST NAME	MIDDLE NAME
DATE OF BIRTH	PHONE NUMBER	STUDENT NUMBER

STUDENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Section II:** Should be completed by Dean of Students or similar official.

Has this student been involved in any disciplinary action at your school or does he/she have any conduct cases pending?  Yes  No

Are there any factors – academic, social, personal, etc. – that would interfere with this student's ability to make normal progress toward his/her degree?  Yes  No

If you answered yes to either question, please explain:

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

College/University: \_\_\_\_\_

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