

MINORITY STUDENTS IN HEALTH CAREERS MOTIVATION PROGRAM

Please type or print 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	
PERSONS WHO WILL KNOW YOUR LOCATION IN TWO YEARS (I.E. RELATIVES, CLOSE FRIENDS, ETC.)				
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 ST 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"/> STUDENT/FRIEND <input type="checkbox"/> OFFICE OF ACADEMIC ENHANCEMENT <input type="checkbox"/> RECRUITER/COUNSELOR <input type="checkbox"/> WEBSITE <input type="checkbox"/> OFFICE OF DIVERSITY & MULTICULTURAL AFFAIRS/ <input type="checkbox"/> INFORMATION SESSION <input type="checkbox"/> MAGAZINE/NEWSPAPER MILLER SCHOOL OF MEDICINE				



UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE



Office of Diversity and Multicultural Affairs
Rosensteil 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

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
www.miami.edu/motivationprogram

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

Return applications to Office of Diversity, Motivation 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
---	--------------------------------

PRIMARY CARETAKER (CHECK ONE) <input type="checkbox"/> MOTHER <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	

SECONDARY CARETAKER (CHECK ONE) <input type="checkbox"/> MOTHER <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	

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

**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 reporting of statistical data.*

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IV. Academic Information

Colleges/Universities attended

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.

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 recommendation letters for you.

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 | <input type="checkbox"/> Dean of Students Recommendation Form |
| <input type="checkbox"/> Official Transcript(s) | <input type="checkbox"/> Personal statement, minimum of 400 words |
| <input type="checkbox"/> Three (3) letters of recommendation, two (2) must be from college professors | <input type="checkbox"/> Wallet-Size Photo |
| <input type="checkbox"/> Proof of Health Insurance (Required) | <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.

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 Academic Enhancement, Motivation Program, 5185 Ponce de Leon Blvd, Coral Gables, Florida 33146

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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