



# CAHCON

## Central Appalachian Health Careers Opportunity Network

WEST VIRGINIA UNIVERSITY AND WESTERN MARYLAND AHEC

HEALTH CAREERS OPPORTUNITY PROGRAM

SUMMER EDUCATIONAL ENRICHMENT PROGRAMS

### FE/RE APPLICATION

This program is funded by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Disadvantaged Assistance. The information requested here is confidential and is required for future funding purposes. **(Please type or print in ink)**

For which program are you applying?

- Facilitating Entry
- Retention

TODAY'S DATE: \_\_\_\_\_

Name: \_\_\_\_\_  
 (last, suffix) (first) (middle) (nickname)

Social Security Number: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Please attach a Wallet-size photo to the top of this page.

U.S. Citizen:  Yes  No If not, Visa status: \_\_\_\_\_

Racial/ethnic self-description—Requested for reporting purposes per federal guidelines.(Check only one):

- Black/African American
- American Indian or Alaskan Native
- White
- Native Hawaiian or other Pacific Islander
- Hispanic or Latino
- Asian
- Other (please specify): \_\_\_\_\_

Present phone number and mailing address:

Telephone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_  
(street/box number)

\_\_\_\_\_  
(city) (state) (zip)

County \_\_\_\_\_

Permanent phone number and mailing address:

Telephone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_  
(street/box number)

\_\_\_\_\_  
(city) (state) (zip)

County \_\_\_\_\_

#### Family Background: Completed Education

	High School	4 year Degree	Advanced Degree (e.g. MS, PhD, MD)	Occupation
Mother's education:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Father's education:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardian's education:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**PERSONAL INFORMATION**

Number of brothers and/or sisters who are attending or have graduated from either a two- or four-year college: \_\_\_\_\_

What is your career choice? Please enter a 1 for first choice and 2 for second choice

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allopathic Physician | <input type="checkbox"/> Osteopathic Physician | <input type="checkbox"/> Dentistry          |
| <input type="checkbox"/> Pharmacy             | <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Medical Technology |
| <input type="checkbox"/> Dental Hygiene       | <input type="checkbox"/> Occupational Therapy  |   |

Are you an Alumnus of any of following programs? (*Check all that apply*)

- |  |                                       |
|--|---------------------------------------|
| HCOP<br><input type="checkbox"/> Yes <input type="checkbox"/> No                 | If yes year(s) of participation _____ |
| HSTA<br><input type="checkbox"/> Yes <input type="checkbox"/> No                 | If yes year(s) of participation _____ |
| Brush with Dentistry<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If yes year(s) of participation _____ |
| SHARE<br><input type="checkbox"/> Yes <input type="checkbox"/> No                | If yes year(s) of participation _____ |
| HSS<br><input type="checkbox"/> Yes <input type="checkbox"/> No                  | If yes year(s) of participation _____ |

If you are **not** claimed as a dependent, respond to these questions (1-4) as **an individual** in order to document eligibility. Please do not leave this section information blank.

1. What was your parents' or legal guardian's adjusted gross income as reported on the most recent Federal Income Tax Form 1040 or 1040A?

Individual return (mother): \$ _____	Individual return (father): \$ _____	Joint return: \$ _____	Legal guardian: \$ _____	Individual return (student): \$ _____
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2. How many people (including parents or guardian and self) are supported by the income listed above?  
\_\_\_\_\_

3. How can this be verified? (e.g., tax forms) \_\_\_\_\_

4. How will your college education be financed?

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Financial aid loan            | <input type="checkbox"/> Parent(s) |
| <input type="checkbox"/> Scholarship                   | <input type="checkbox"/> Self      |
| <input type="checkbox"/> Other (please specify): _____ |                                    |

The table below provides a breakdown of family income levels used to determine economic disadvantaged status. Family income is defined as your parents'/guardians' income.

Size of Family Unit	1	2	3	4	5	6	7	8
Income Level	\$17,960	\$24,240	\$30,520	\$36,800	\$43,080	\$49,360	\$55,640	\$61,920

**DEFINITIONS:**

***Economic Disadvantage:*** an individual that comes from a family with an annual income at or below low-income thresholds according to family size (see chart above).

***Educational/Social Disadvantage:*** an individual that attended a school that inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school or allied health program, e.g., an individual attended a school which did not offer advanced math or science courses, an individual whose family members have never attended or graduated from college, or attended a high school in which you were a member of an under-represented minority group.

Which of the above criteria do you meet?

- Economically Disadvantage  
 Educationally/Socially Disadvantage

Are there any family circumstances, health, or special problems, which may be useful for us to know in evaluating your application?

- Yes If yes, please explain (use additional sheets if necessary):  
 No

List in chronological order, following high school, all colleges or universities attended or currently attending:

INSTITUTION	MAJOR	DEGREE	DATES ATTENDED

Present classification in college:  
 \_\_\_\_\_ Freshman      \_\_\_\_\_ Junior      \_\_\_\_\_ Graduate  
 \_\_\_\_\_ Sophomore      \_\_\_\_\_ Senior      \_\_\_\_\_ Other: (please explain)

Overall GPA: \_\_\_\_\_ Science GPA: \_\_\_\_\_

Expected Date of Graduation from college: \_\_\_\_\_

Do you have an advisor? \_\_\_\_\_ Yes If yes, please name \_\_\_\_\_  
 \_\_\_\_\_ No

Have you applied to this program previously?  
 Yes  No If yes, year(s): \_\_\_\_\_

Have you applied to medical/dental/pharmacy/allied health school this year?  
 Yes If yes, indicate which school(s) and year(s): \_\_\_\_\_  
 No \_\_\_\_\_

Have you been accepted to medical/dental/pharmacy/allied health school or program  
 Yes If yes, indicate which school (s) and year: \_\_\_\_\_  
 No \_\_\_\_\_

Do you intend to apply to medical/dental/pharmacy/allied health school in the fall?  
 Yes If not, indicate which school(s) and years(s) you intend to make application:  
 No \_\_\_\_\_

Have you been involved in other summer programs since your graduation from high school?  
 Yes If yes, indicate which program(s): \_\_\_\_\_  
 No \_\_\_\_\_

If you have taken the Medical College (MCAT), Dental College (DAT), Pharmacy College (PCAT), Graduate Records Examination (GRE) or Allied Health Professions (AHPAT) Admission Test, list scores (If taken more than once, list last two tests):

<u>MCAT</u>	<u>DAT</u>	<u>PCAT</u>
Verb Reas    ___/___	Academ Avg    ___/___	VerbalAbi    ___/___
Phys Sci    ___/___	Percep Abil    ___/___	Reading Comp    ___/___
Biol Sci    ___/___	Quant Reas    ___/___	Biology    ___/___
Writing    ___/___	Reading    ___/___	Chemistry    ___/___
	Biology    ___/___	Quant Abil    ___/___
<u>GRE</u>	Inorg Chem    ___/___	Arith Skills    ___/___
Verb    ___/___	Org Chem    ___/___	Math Reas    ___/___
Quant    ___/___	Total Sci    ___/___	
Analyt    ___/___		<u>APHAT</u>
		Biology    ___/___
		Chem    ___/___
		Verbal    ___/___
		Quant    ___/___
		Reading    ___/___

Date of first test: (month/year): \_\_\_\_\_  
 Date of second test: (month/year): \_\_\_\_\_

**EDUCATION INFORMATION**

## ESSAY:

Please choose three topics and write an essay in which each one is addressed (incorporate topics into one essay).

1. Describe a circumstance or obstacle that has had an impact on your life and how did this circumstance or obstacle influence your interest in a career in medicine?
2. Describe why you believe you can succeed in a Health Career.
3. Describe your personal strengths and commitments that have helped you attain your current level of education.
4. Describe how learning about Health Careers will be of benefit to you in planning for your future?

## Guidelines

- ? Essay should be no more than 1 page long , double spaced, 12 point font, Times New Roman
- ? Essay is to be submitted with your application

## Helpful Hints:

- ? Write from your heart. Let the reader know who you are and **NOT** who you want them to think you are. The essay in which you are honest about your feelings and experiences is most powerful.
- ? There is no "perfect essay" formula. As long as what you are writing addresses the topics you choose clearly, thoughtfully, and with attention to grammar, you will increase your potential for the "perfect essay."
- ? Practice makes perfect. It takes several drafts to create a well-written essay. Developing an outline of what you are going to write about will help you better organize your thoughts.
- ? Don't stress. You are writing on a subject you know well. Yourself!

## Recommendations:

List names, positions, and subjects taught by teachers from math and/or science that you have asked to write letters of recommendation:

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Subject taught: \_\_\_\_\_

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Subject taught: \_\_\_\_\_

## COMMITMENT:

By my signature below, I hereby certify that the information on this application is true and accurate to the best of my knowledge. In addition, I understand that if I am selected for this program , I am required to attend all scheduled program functions, including weekend and evening activities.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**DEADLINE:**

Your total application must be received by **April 1** and must include:

1. COMPLETED APPLICATION FORM (omitting any answers will invalidate your application);
2. OFFICIAL TRANSCRIPT sent directly to us by all high schools or colleges you have attended;
3. TYPED ONE PAGE ESSAY; and
4. LETTERS OF RECOMMENDATION sent directly to us by the recommenders.

For further information or if you have questions, please call the numbers or write to the addresses below.

**FOR MEDICINE, DENTISTRY, OR PHARMACY SEND TO:**

HEALTH CAREERS OPPORTUNITY PROGRAM  
WEST VIRGINIA UNIVERSITY  
ROBERT C. BYRD HEALTH SCIENCES CENTER  
PO BOX 9026  
MORGANTOWN WV 26506-9026  
(304) 293-2420 or 1-800-345-HCOP (WV only)

OR

**FOR ALLIED HEALTH SEND TO:**

WESTERN MARYLAND AHEC  
11 COLUMBIA STREET  
CUMBERLAND MD 21502  
(301) 777-9150

Application may be photocopied.

You may also obtain more information from our website at **[www.cahcon.org](http://www.cahcon.org)**.

## Completed Application Checklist

- 1. Personal Information
- 2. Wallet-size photo (Photo will not be returned)
- 3. Program Information
- 4. Family Background
- 5. Financial Information
- 6. Educational Information
- 7. Transcripts
- 8. Essay
- 9. Recommendations (2)

**Incomplete Applications Will Not Be Accepted**

# Recommendation

Name of Applicant \_\_\_\_\_

Current Institution Attending \_\_\_\_\_

I waive ( ) I do not waive ( ) my right of access to this recommendation form under the Family Educational Rights and Privacy Act of 1974, 20 U.S.C.A. par 1232g(a)(1). I understand that this form will be used by West Virginia University solely in its procedures relating to acceptance to the HCOP Program.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Recommender \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_

Phone\_(\_\_\_\_) \_\_\_\_\_ Pager\_(\_\_\_\_) \_\_\_\_\_

Fax\_(\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

How long and in what capacity have you known the applicant? \_\_\_\_\_

Dear Recommender,

The Central Appalachian Health Careers Opportunity Network (CAHCON) is a comprehensive program to provide students with the knowledge, skills, support, and abilities to enter and graduate from colleges and universities offering careers in allied health, medicine, dentistry, and pharmacy. This applicant is applying to the Summer Health Career Opportunity Program (HCOP) at West Virginia University. This is an intensive summer program sponsored by HCOP. The objectives of the HCOP Summer Program are to encourage and facilitate students from educationally and economically disadvantaged backgrounds to seek and successfully graduate from a health professions school.

Your candid assessment of the applicant's ability and potential would be greatly appreciated. The selection committee is particularly interested in your assessment of the following about the applicant: 1. Performance in your class (es), if applicable; 2. Academic talent; 3. Personal character; 4. Potential to pursue a career in a health profession.

This form must be **postmarked by April 1** Please submit to:

HEALTH CAREERS OPPORTUNITY PROGRAM  
 WEST VIRGINIA UNIVERSITY  
 ROBERT C. BYRD HEALTH SCIENCES CENTER  
 PO BOX 9026  
 MORGANTOWN WV 26506-9026

**5- Outstanding 4- Above Average 3- Average 2- Below Average 1- Poor 0- unable to rate**

CRITERIA	RATING	PLEASE USE THIS SECTION TO ADD COMMENTS
Professionalism/Maturity		
Reliability/Responsibility		
Problem Solving abilities		
Commitment level		
Communications skills		
Self-discipline		
Ability to work with others		

Recommender Signature \_\_\_\_\_ Date \_\_\_\_\_

# Recommendation

Name of Applicant \_\_\_\_\_

Current Institution Attending \_\_\_\_\_

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Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Recommender \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_

Phone\_( ) \_\_\_\_\_ Pager\_( ) \_\_\_\_\_

Fax\_( ) \_\_\_\_\_ E-mail \_\_\_\_\_

How long and in what capacity have you known the applicant? \_\_\_\_\_

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 MORGANTOWN WV 26506-9026

**15- Outstanding 4- Above Average 3- Average 2- Below Average 1- Poor 0- unable to rate**

CRITERIA	RATING	PLEASE USE THIS SECTION TO ADD COMMENTS
Professionalism/Maturity		
Reliability/Responsibility		
Problem Solving abilities		
Commitment level		
Communications skills		
Self-discipline		
Ability to work with others		

Recommender Signature \_\_\_\_\_ Date \_\_\_\_\_