

HCOP

Health Careers Opportunity Program

FE 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)**

TODAY'S DATE: _____

How did you hear about this program? _____

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:

(street/box number)

Telephone: (____) _____

Email: _____

(city) (state) (zip)

County _____

Permanent phone number and mailing address:

(street/box number)

Telephone: (____) _____

Email: _____

(city) (state) (zip)

County _____

Family Background: **Completed Education**

	Name	Highest Education Received	Occupation (Please List)
Mother's			
Father's			
Guardian's			

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
<input type="checkbox"/> Yes <input type="checkbox"/> No | If yes year(s) of participation _____ |
| HSTA
<input type="checkbox"/> Yes <input type="checkbox"/> No | If yes year(s) of participation _____ |
| Brush with Dentistry
<input type="checkbox"/> Yes <input type="checkbox"/> No | If yes year(s) of participation _____ |
| SHARE
<input type="checkbox"/> Yes <input type="checkbox"/> No | If yes year(s) of participation _____ |
| HSS
<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 any of 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):
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

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?
 Financial aid loan Parent(s)
 Scholarship Self
 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:

Educational Disadvantage: an individual that comes from an environment that has 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., a person who is first generation in their family to attend and graduate from a 4 year College/University, or who graduated from a high school that had limited upper level courses.

Economic Disadvantage: an individual that comes from a family with an annual income at or below low-income thresholds according to family size.

Do you meet the above eligibility criteria? Yes No Unsure

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): _____

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 350 words/ 1500 characters / 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 Professors/Teachers that you have asked to write letters of recommendation. *Note that it's important to get someone that you have had for class and knows you well.*

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 3** 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. 2 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.

HEALTH CAREERS OPPORTUNITY PROGRAM
WEST VIRGINIA UNIVERSITY
ROBERT C. BYRD HEALTH SCIENCES CENTER
PO BOX 9027
MORGANTOWN WV 26506-9027
(304) 293-2420 or 1-800-345-4267 ext. 1 (WV only)

Application may be photocopied.

You may also obtain more information from our website at **www.wvhcop.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.