

UIC

University of Illinois at Chicago College of Medicine Department of Medical Education - Hispanic Center of Excellence

808 S. Wood Street 990 CME (MC591)

Chicago, Illinois 60612-7333

Phone: (312) 996-4493 Fax: (312) 996-9922

**PLEASE CHECK THE PROGRAM (S) YOU ARE APPLYING FOR AND
USE THE CHECKLIST TO COMPLETE YOUR APPLICATION**

❑ **MEDICINA SCHOLARS PROGRAM FOR UNDERGRADUATES**

- ❑ Complete all sections of the application.
- ❑ Attach a one page typed personal statement about your educational and career goals.
- ❑ Provide a copy of school transcripts.
- ❑ Provide 2 letters of recommendation from faculty.

Requirements:

- ❑ Student of Hispanic Origin
- ❑ Conversational Spanish
- ❑ Freshman or Sophomore standing at an accredited university, as of fall 2005
- ❑ 3.0 GPA (A=4.0)
- ❑ Minimum 21 ACT for incoming Freshmen
- ❑ Good academic standing, community involvement, and demonstrated interest in medicine.

Deadline: Application must be received by August 31, 2005

❑ **ESCUCHA LEADERSHIP DEVELOPMENT CONFERENCE**

Scheduled for MAY 12 and MAY 13, 2006

- ❑ Complete all sections of the application.
- ❑ Attach a one page typed personal statement about your educational and career goals
(You may use your medical school personal statement)

Requirements:

- ❑ Students of Hispanic Origin
- ❑ Undergraduate or Medical Students may apply
- ❑ Good academic standing, community involvement, and career track in medicine

Deadline: Application must be received by March 10, 2006

❑ **SUMMER MEDICAL STUDENT RESEARCH FELLOWSHIP**

Scheduled for JUNE 2 thru AUGUST 11, 2006

Requirement: For First Year Medical students at UIC or UIUC only

- ❑ Complete all sections of the application
- ❑ List any UIC or UIUC employment and your UIN Number _____
- ❑ Area of research interest: _____
- ❑ Indicate preference: ____ Clinical ____ Laboratory
- ❑ Student can fulfill research in the state of Illinois or other states pending approval

Deadline: Application must be received by March 10, 2006

**These programs are supported through a grant awarded by the Division of Health Professions Diversity,
Health Resources and Services Administration and U.S. Department of Health and Human Services.**

STUDENT DATA

DATE _____

Name _____
Last First Middle

Social Security Number _____ Date of Birth ____ / ____ / ____ Sex ____ F ____ M

Permanent Address (Home) _____

City State County Zip Code

Current Address (Academic Year) _____

City State County Zip Code

Home Phone _____ **Work Phone** _____ **E-mail** _____

U.S. Citizen _____ **Permanent Resident** _____ **Alien Visa Number** _____

Race (check if applies):

- American Indian or Alaskan Native
- Asian
- Black or African American
- White not of Hispanic Origin
- Native Hawaiian or Pacific Islander

Please specify

Ethnicity (may check multiple choices):

- Cuban
- Mexican American
- Puerto Rican

Other Hispanic _____

Please Specify

<u>FAMILY DATA</u>	Living	Deceased	Occupation	State of Residence	Education (Level Completed)
Father's Name,					
Mother's Name					
Guardian's Name					

Year Sibling born - Sister (s) _____ Year Sibling born - Brother(s) _____

IF MARRIED Spouses Name					
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Year (s) your Children were born: _____

AWARDS/HONORS

Please list any awards and honors received (e.g., academic, community service, volunteer work etc.)

EMPLOYMENT

Please list any jobs you have held and the **approximate hours worked per week.**

List any employment at the University of Illinois with your UIN number. May attach resume.

EMPLOYER

EMPLOYMENT DATES/HOURS

Please list Biology, Chemistry, Physics, and Math (BCPM) courses, grades, and indicate the date of completion.

COURSE NUMBER

GRADE

DATE/YEAR

CURRENT BCPM GPA: ____/4.0

IF APPLYING TO MEDICAL SCHOOL

What year will you apply? _____

Have you ever taken the MCAT ____ YES ____ NO if yes; please list date(s) _____

MCAT SCORES

Verbal Reasoning _____ Physical Science _____

Biological Science _____ Writing Sample _____

I certify that the information submitted on this application is complete and correct to the best of my knowledge.

Signature of applicant: _____ Date: _____

Please submit completed application to:

**University of Illinois at Chicago College of Medicine
Department of Medical Education – Hispanic Center of Excellence
808 S. Wood Street 990 CME (MC591)
Chicago, Illinois 60612-7333**

Office use only:

Student name: _____ Date: _____

OFFICE USE	DATE ACCEPTED & INITIALS	TRANSCRIPTS ATTACHED	PERSONAL STATEMENT	GPA	REC LETTERS
MEDICINA SCHOLARS					
LEADERSHIP DEVELOPME CONFERENCE					
SUMMER MEDICAL STUDENT RESEARCH					

REVIEWER COMMENTS