

California State University, Los Angeles

Level III (Matriculating Students) Summer Intensive Program

Health Careers Opportunity Program (HCOP)

c/o Department of Biology and Microbiology

5151 State University Drive

Los Angeles, CA 90032-8207

Application for Admission

Application Check List

Letters of Recommendation from your Pre-Health Professional Office

College or University Transcripts (most recent)

Copy of Acceptance Letter

Copy of Personal Statement

PERSONAL INFORMATION

NAME:

Last

First

Middle

MAILING ADDRESS:

Number & Street

City

State

ZIP

()
Day/Work Phone

()
Evening Phone

()
Pager/Voicemail

Social Security Number

Birthplace (Country & State)

Date of Birth (Month Day Year)

Are you a U.S. Citizen?

or a permanent resident of the U.S.?

Alien Registration Number: _____

Country of citizenship if other than the U.S.

Academic Information

College or University: _____

Current College Status: College Graduate _____ Post-Bac. _____ Graduate Student _____

Undergraduate major: _____ Graduation Date: _____

Graduate major (if applicable): _____ Expected graduation date: _____

Current GPA: _____ Science GPA: _____

List in chronological order beginning with high schools, colleges, universities or institutions attended or currently attending. Include summer programs.

Institution	Major Course of Study	Year & Month of Degree/Diploma	Dates Attended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current career goal/plans (Medicine, Dental, Research, etc.)

Give the name, address and phone number of someone (a relative or friend) who does not live with you but can be contacted in the event of an emergency. A telephone number is mandatory.

Name _____ Address _____

City _____ Zip Code _____

(_____) _____
Telephone Number _____ Relationship _____

Career Choices

Medical School _____ Dental School _____ Pharmacy School _____
Optometry School _____ Osteopathy _____ Podiatry _____
Veterinary Medicine _____ Chiropractic _____ Other _____
(i.e., Physician Assistant, etc.)

Professional School Application

List Professional Schools you plan to apply to and the year of anticipated entry (i.e., medical school, dental school, graduate school, etc.)

a) _____ _____ _____
Type of school year of anticipated entry projected entry date

b) _____ _____ _____
Type of school year of anticipated entry projected entry date

List of professional school entrance/qualifying examinations you have taken or plan to take (i.e., MCAT, DAT, OAT, GRE, etc.)

a) _____ _____ _____
Name of test Date Scores, if available

b) _____ _____ _____
Name of test Date Scores, if available

c) _____ _____ _____
Name of test Date Scores, if available

APPLICANT INFORMATION (Confidential)

The table below provides family income levels used to determine economically disadvantaged students. The figures used to determine low income eligibility for the purposes of Health Careers Opportunity Program (HCOP) grants are those reported by the U. S. Census Bureau and are subject to change in the future years.

Please use chart below to select the correct category:

- _____ Above Low-Income Level
- _____ At Low-Income Level
- _____ Below Low-Income Level

INCOME LEVEL:

Number of Family Members*	Income per Year**
1	\$ 10,700
2	13,900
3	16,500
4	21,200
5	25,000
6 OR MORE	28,100

* Number of Family Members - Includes only dependents listed on Federal Income Tax forms

** Income Level - Adjusted gross (before taxes) income for calendar year 1998

Are you financially disadvantaged and/or eligible for financial aid?
 (Please circle one) Yes No

Please attach a copy of your 1040 Income Tax Form for the previous year.

Parents Education:

Father: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4
 Mother: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4

Language spoken at home: English____ Spanish____ Both____ Other_____

Family Information:

Brother/Sister/Child's Name	Age	Do they live with you?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Ethnicity:

- American Indian/Alaskan Native Hispanic _____ African American
- Asian/Pacific Islander Caucasian Other:_____

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

Signature

Social Security Number

**CALIFORNIA STATE UNIVERSITY, LOS ANGELES
HEALTH CAREERS OPPORTUNITY PROGRAM**

GENERAL MEDICAL INFORMATION

To be filled out by applicant or, if under 18, student's parents/guardian:

Please complete the following in order that the doctor and nurse who will be treating you may have as much information as possible in case he/she needs medical help for an illness or injury while attending our program.

Date: _____

Student's Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

Address: _____
Street & Number City State ZIP

Telephone: () ()
Home Phone Work Phone

Name of Parent or Guardian (or person to be notified in an emergency):

Name: _____
Last First MI

Telephone: () ()
Home Phone Work Phone

Parent/Guardian Employer: _____

Parent/Guardian Occupation: _____

Do you have any health insurance? Yes No

If yes, name of the insurance plan & telephone number:

Do you belong to a clinic? Yes No

If yes, name of the clinic & telephone number:

Do you have a doctor you wish called in the case of a medical emergency? Yes No

If so, name of the doctor & telephone number: _____

Present Health: Excellent Good Poor

Past Health: Excellent Good Poor

Has any blood relative had:

Have you ever had:

Tuberculosis: Yes No

Tuberculosis: Yes No

Diabetes: Yes No

Diabetes: Yes No

Cancer: Yes No

Cancer: Yes No

Kidney Trouble Yes No

Kidney Trouble Yes No

Asthma Yes No

Asthma Yes No

Are you allergic to any foods or medication? (e.g., aspirin, penicillin, milk, etc?) Yes No

If yes, what are you allergic to: _____

List any medication(s) that you are presently taking: _____

Signature of Student

Date

**CALIFORNIA STATE UNIVERSITY, LOS ANGELES
HEALTH CAREERS OPPORTUNITY PROGRAM (HCOP)**

CONSENT TO RELEASE INFORMATION

**TO: ANY PUBLIC OR PRIVATE MEDICAL, PSYCHOLOGICAL,
EDUCATIONAL, SOCIAL SERVICES AGENCY OR ORGANIZATION.**

I, the undersigned hereby give authorization to release or obtain college records, and /or pertinent social, medical, and psychological information from your records on _____
to the Health Careers Opportunity Program (HCOP) at California State University, Los Angeles for professional use only.

Signature of Applicant,
or if under 18, Parent/Guardian

Date