

2010 Future Health Leaders Summer Program Application Check List

Please complete this form and return it to the EAHEC office by **April 30, 2010**.

- All 2010 Future Health Leaders Summer Program application forms are included and:
 - Student and one parent/guardian have signed the application forms.
- One (1) completed recommendation form is included and:
 - The form is sealed in a separate envelope with the teacher's signature across the flap.
- Medical Release Form
- Transportation/T-Shirt Form
- Photo Release Form
- The EAHEC office will receive all application materials by April 30, 2010.
- All application materials mailed to:
EAHEC
Attn: Jean Campbell
5880 S. Hospital Dr.
Globe, AZ 85501

Please provide us with your e-mail address, if any:

An e-mail or written letter will be sent to you once all application materials have been received & reviewed by the AHEC staff.

Please note that it is the responsibility of the student to make sure that all application materials have been submitted, on time, to EAHEC. Incomplete and late applications will not be considered.

EAHEC
Jean Campbell
5880 S. Hospital Dr Globe, AZ 85501
928-402-8054
cjcampbell@cableone.net

2010 Future Health Leaders Summer Program

PARTICIPANT APPLICATION FORM

Please complete this form and return it to:

EAHEC

Attn: Jean Campbell

5880 S. Hospital Dr

Globe, AZ 85501

By April 30, 2010

Please print neatly using blue or black ink on all application forms.

A) PERSONAL INFORMATION: This section must be completed by the student applicant.

Date: ___/___/___ High School: _____ Grade: _____

Student Name: Last _____ First _____ M.I. _____
(as it will appear on the certificate of completion)

Student's e-mail: _____

Social Security #: ___ - ___ - _____ Phone #: (___ - ___) ___ - _____

Mailing Address:

PO Box or Street Address

City

County

State

Zip Code

Gender: () Female () Male

Date of Birth: ___ / ___ / ___

Ethnicity: (please select only one)

() American Indian or Alaska Native

() White/Caucasian

() Native Hawaiian/Other Pacific
Islander

() Black or African American

() Hispanic/Latino/Mexican American

() Asian

() Other _____

Are you a member of the health career club: () No () Yes: Starting year _____

What are your career choices at the present time? Please number your top three choices. If you mark other please specify what other career you would like to explore.

() Medical Doctor

() Nursing

() Naturopathic Doctor

() Pharmacist

() Public Health

() Chiropractic

() Physical Therapy

() Dentist

() Allied Health

() Physician Assistant

() Dental Hygienist

() Other _____

Expected Graduation Date: Month _____ Year _____

B) PARENTAL PERMISSION: This section must be completed by the student's parent/guardian.

I, " _____ " have read the 2010 Future Health Leaders Summer Program Information inviting my son/daughter, " _____," to participate in this activity. I have decided to give him/her permission to attend. Please contact me at your earliest convenience to provide me and my son/daughter with additional information. I have reviewed and understand all of the summer program registration/application forms.

(Parent/Guardian Signature)

Date

C) Essay Questions: This section must be completed by the student applicant.

Please answer these questions to help us understand why you are seeking a career in the health professions (if needed, please attach additional pages).

1. Which health profession do you want to pursue the most and why?

2. Briefly describe a major health problem in your community and how, as a health professional, you would address it.

May we contact you in your year of graduation from high school to find out where you are in the process of achieving your personal career goals? () Yes () No

2010 Future Health Leaders Summer Program Recommendation Form

Please complete this form and return it to the EAHEC office by April 30, 2010.

This student has asked you to provide an assessment of his/her suitability as a participant in the 2010 Future Health Leaders Summer Program. We are interested in selecting students who have:

Previously demonstrated an interest in health careers (or could benefit from learning about such options).

Demonstrated past academic achievement, or whom you feel are capable of handling a college curriculum in the future (but whose grades may not presently reflect this).

Please return this recommendation form to THE STUDENT in a sealed envelope with your name signed across the flap.

Student's Name: _____

School: _____

Evaluator's Name: _____ Date: _____

Signature: _____

Position/Department: _____

Phone Number: _____ e-mail address: _____

Thank you for taking the time to provide this important information.

Student's **strengths** as you see them:

Student's **weaknesses** as you see them (areas that may be improved, none apparent is an acceptable answer):

Summary Evaluation: Overall impression of the student and additional comments.

In comparison with other students you have known; please evaluate the applicant in the following areas:

	<i>Poor</i>			<i>Outstanding</i>	
INTELLECTUAL CAPACITY: <i>Ability to gather, integrate and work with information</i>	1	2	3	4	5
MOTIVATION: <i>Genuineness, desire and depth of commitment to the health care profession</i>	1	2	3	4	5
MATURITY: <i>Personal development, ability to cope with life situations</i>	1	2	3	4	5
INTERPERSONAL RELATIONS: <i>Ability to get along with others, rapport, cooperation, attitude toward supervision</i>	1	2	3	4	5
EMPATHY: <i>Sensitivity to the needs of others, consideration, tactfulness</i>	1	2	3	4	5
EMOTIONAL STABILITY: <i>Performance under pressure, mood stability, ability to relate to others</i>	1	2	3	4	5
ANALYTICAL SKILLS: <i>Ability to problem solve, correlate and process information, and to think critically.</i>	1	2	3	4	5
JUDGMENT: <i>Ability to evaluate a problem involving people, common sense and decisiveness</i>	1	2	3	4	5
RESOURCEFULNESS: <i>Ability to discover new resources and to manage new and already present resources skillfully</i>	1	2	3	4	5
RELIABILITY: <i>Dependability, sense of responsibility, promptness, conscientiousness</i>	1	2	3	4	5
LEADERSHIP: <i>Ability to initiate, lead and/or supervise others</i>	1	2	3	4	5
COMMUNICATION <i>Verbal skills, clarity of expression, articulateness</i>	1	2	3	4	5
SKILLS: <i>Clarity and conciseness of written expression</i>	1	2	3	4	5
PERSEVERANCE: <i>Energy, endurance, desire to succeed, ability to overcome obstacles</i>	1	2	3	4	5
INTEGRITY: <i>Honesty, trustworthiness, uprightness,</i>	1	2	3	4	5
CREATIVITY: <i>Ability to generate new and novel ideas, or approaches to problems</i>	1	2	3	4	5
Overall Recommendation:					
<input type="checkbox"/> This applicant receives my this highest recommendation without reservation		<input type="checkbox"/> I recommend this applicant with confidence		<input type="checkbox"/> I recommend this applicant applicant for admission	

Any questions, please call or e-mail

EAHEC

Jean Campbell

(928) 402-8054

cjcampbell@cableone.net



Student Name: *Last* _____ *First* _____ *M.I.* _____

School Name: _____

A) Transportation Agreement

Each AHEC strongly encourages parents/guardians to transport their sons/daughters selected to participate in this workshop to and from the location of the 2010 Future Health Leaders Summer Program (The Northern Arizona University campus in Flagstaff).

By signing this form, I ensure that: (you may select more than one option)

- () I will transport my son/daughter to the Northern Arizona University campus on Sunday, July 11th, for the 2010 Future Health Leaders Summer Program, and will pick him/her up and return my home on Friday, July 23, 2010. Students should arrive at NAU by 3:00 pm on July 11th, and pickup students at NAU by 4:00 pm on July 23rd.
- () I volunteer to transport other students from my son/daughter's high school to and from the 2010 Future Health Leaders Summer Program

Parent/Guardian Signature

Date

(please print parent/guardian's name)

B) T-Shirt Size Information

Students participating in the 2010 Future Health Leaders Summer Program will receive one free T-shirt. Students should wear this T-shirt during the group photo activity and during field trips. To receive the appropriate T-shirts, please provide the information requested below:

Student Gender: () Female () Male

Please check only one size for the T-shirt:

- () S (Small) () M (Medium) () L (Large)
- () XL (Extra Large) () XXL (Extra Extra Large)



2010 Future Health Leaders Summer Program

Release For Use Of Photographic Images

I hereby grant the Northern Arizona AHEC, Eastern Arizona AHEC, Greater Valley AHEC, South Eastern AHEC, Western AZ AHEC, the right to publish and display photographic images, videotape, and or voice recordings of myself taken during the 2010 Future Health Leaders Summer Program. I understand that such publications will be used for brochures, websites, display boards, and or conference materials, for this non-profit organization. I understand that my likeness will not be used for any financial gain and that I may choose not to sign this waiver without penalty. I waive all rights to fees and compensation for the use of these photographs, which are the property of the Arizona Area Health Education Centers.

Signed: _____

(Print Name): _____

Date: _____



2010 Future Health Leaders Summer Program

Selected participants and their parents/guardians must provide the following information to participate in the 2010 Future Health Leaders Summer Program.

Student Name: _____

Please answer Yes or No to the following questions:

1. Are you currently pregnant? () Yes () No If yes, please provide due date: _____

2. Do you smoke? () Yes () No If yes, please note that it is against state law for minors to possess or use tobacco. We will enforce this law during the workshop.

3. Do you follow any special diet? () Yes () No If yes, please specify: _____

4. Do you have any of the following conditions? () Diabetes () Epilepsy () Seizures () Other,

Please specify: _____

5. Other medical problems, chronic conditions or special situations about which we should know:

6. Do you require American with Disability Act-related assistance? () Yes () No If yes, please

specify your requirements so that we can accommodate: _____

7. Adverse reactions: Please list and describe any adverse reactions that you may have had to medications:

8. Please list and describe any food allergies that you may have:

9. Please list any other allergies that you may have (e.g. surgical tape, bee sting, etc.):

10. Medications: Please list any medications that you take regularly and will bring with you to the workshop (include vitamins, prescription & non-prescription medications, oral contraceptives, etc.):

(Medications brought to the workshop must be listed above and be in their original packaging).

11. Consent to Treat 17 Year Old or Younger 2010 Future Health Leaders Summer Program Participants *(this section must be completed by the student's parent or guardian)*

I give permission to the AHEC Health Career Program Director to arrange emergency medical care for my son/daughter in the event of an accident or illness and hereby grant permission to any licensed medical doctor, nurse, dentist, or other health care professional to provide treatment as deemed necessary.

If any student is not covered under a health care or medical insurance plan, charges for any treatment for illness or injury occurring during the summer program will be sent directly to the parent/guardian by the health care facility involved.

Signature of Parent /Guardian: _____ Date: _____

Please Print Parent/Guardian Name: _____

In case of an emergency, contact: _____

Daytime Phone #: (____) _____ - _____ Evening Phone #: (____) _____ - _____
