



**HEALTH CAREERS OPPORTUNITY PROGRAM
PRIMARY CARE EXPOSURE ACTIVITY
APPLICATION**

SOCIAL SECURITY # _____ - _____ - _____

NAME _____
LAST FIRST MI

MAILING ADDRESS: _____
STREET/P.O. BOX

CITY STATE ZIP

DAY PHONE#: (____)____-____ EVENING PHONE#: (____)____-____

E-MAIL: _____

GENDER: MALE ___ FEMALE ___ DATE OF BIRTH _____
MM/DD/YYYY

U.S. CITIZEN: YES ___ NO ___

RACE: CAUCASIAN___ AFRICAN AMERICAN___ NATIVE AMERICAN ___

HISPANIC___ OTHER (please specify) _____

EDUCATIONAL INFORMATION

College Major _____ Fulltime Part Time

Current Classification (Circle one): Sr Jr Soph Fr Overall GPA _____

Name of Advisor _____ Advisor Phone# _____

Have you completed a professional school Admissions Test: Y N

If YES, then list the test, date and scores: _____

Are you a former participant in an HCOP program? YES___ NO___

If YES; list year/program: _____

Career Interest & Experience

Health Career/Profession interest? _____

Previous medical/clinical experience _____

Choice of Primary Care Exposure preferred location(s):

1) _____ City _____

Ph#: _____ Contact: _____

2) _____ City _____

Ph#: _____ Contact: _____

Personal Statement and Recommendation

- 1) Please provide a personal essay describing your background, goals, motivation, experience and health career interests. Include your reason(s) for applying for the Primary Care Clinical Exposure Activity. **The essay should be 400-500 words.**
- 2) Provide at least one **Applicant Evaluation and Recommendation** form completed by your school advisor.

CERTIFICATION AND RELEASE OF INFORMATION

(Must be signed by applicant)

All of the information on this form is true and complete to the best of my knowledge. If requested, I will provide proof of this information to the Director of HCOP. I realize that proof of personal information may include a copy of my federal or state income tax returns for the past year. I also realize that if I do not provide proof of this information when asked, I will jeopardize my participation in the Primary Care Exposure Activity (PCEA).

I understand that I must meet medical and physical qualifications as required by the participating clinic.

I grant representatives from the Health Careers Opportunity Program at the University of North Carolina at Pembroke, permission to receive and/or review copies of all my college transcripts, information relating to financial information, and reports regarding my academic progress.

Signature of Student

Date

Mail completed application to:

Health Careers Opportunity Program, PO Box 1510, Pembroke, NC 28372 or Fax: 910.521.6496