

FIRST NAME

MIDDLE NAME

LAST NAME

SCHOOL

CAPITAL COMMUNITY COLLEGE
AND
THE UNIVERSITY OF CONNECTICUT BRIDGES
NETWORK



ADMINISTERED BY:
HEALTH CAREER OPPORTUNITY PROGRAMS
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FARMINGTON, CONNECTICUT 06030-3920

INSTRUCTIONS TO APPLICANTS (TO ASSIST IN APPLYING FOR ADMISSION)

1. APPLICATIONS ARE CONSIDERED BY THE CAPITAL COMMUNITY COLLEGE MATH AND SCIENCE DEPARTMENT FACULTY UPON COMPLETION.
2. APPLICANTS SHOULD UNDERSTAND IT IS THEIR RESPONSIBILITY TO SUBMIT ALL MATERIAL, INCLUDING RECOMMENDATION LETTERS.

APPLICATIONS CONSIST OF THE FOLLOWING

1. A COMPLETED APPLICATION WITH ESSAY
2. SCHOOL TRANSCRIPT(S) – ACADEMIC SCHOOL YEARS (HIGH SCHOOL OR COLLEGE/UNIVERSITY)
3. TWO (2) RECOMMENDATIONS (PREFERABLY FROM A SCIENCE INSTRUCTOR)

FOR OFFICE USE ONLY

DATE RECEIVED _____

COMPUTER ENTRY _____

FIRST NAME MIDDLE NAME LAST NAME SCHOOL

TO BE COMPLETED BY STUDENT APPLICANT

HAVE YOU PARTICIPATED IN ANY PROGRAMS AT THE UNIVERSITY OF CONNECTICUT HEALTH CENTER IN PREVIOUS YEARS INCLUDING EITHER THE HEALTH CAREER DISCOVERY PROGRAM (CPEP), BULKELEY HIGH SCHOOL OR WEAVER HIGH SCHOOL HEALTH PROFESSIONS ACADEMY, HIGH SCHOOL STUDENT RESEARCH APPRENTICE PROGRAM?

YES NO

IF YES, INDICATE THE UNIVERSITY OF CONNECTICUT HEALTH CENTER PROGRAM(S) IN WHICH YOU HAVE PARTICIPATED AND THE YEAR(S):

CAREER INTEREST: MEDICINE DENTAL MEDICINE BIOMEDICAL RESEARCH NURSING PHARMACY
 PUBLIC HEALTH ALLIED HEALTH (SPECIFY) _____
 OTHER (SPECIFY) _____

PERSONAL INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

1. NAME: _____
FIRST NAME MIDDLE NAME LAST NAME

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

PLACE OF BIRTH: _____

CITIZENSHIP: USA PERMANENT RESIDENT OTHER (SPECIFY) _____

2. LEGAL RESIDENCE: _____
STREET/APARTMENT/PO BOX

CITY STATE ZIP
CODE

AREA CODE/TELEPHONE NUMBER

3. SCHOOL RESIDENCE (IF LIVING ON CAMPUS): _____
STREET/APARTMENT/PO BOX

COLLEGE/UNIVERSITY (IF LIVING ON CAMPUS)

CITY STATE ZIP
CODE

AREA CODE/TELEPHONE NUMBER

4. _____
E-MAIL ADDRESS (MOST FREQUENTLY USED)

FIRST NAME

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FAMILY INFORMATION (ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED COMPLETELY)

GENDER: MALE FEMALE

ETHNICITY:

BLACK/AFRICAN AMERICAN CAUCASIAN NATIVE AMERICAN/ALASKAN MEXICAN AMERICAN/CHICANO

PUERTO RICAN ASIAN NATIVE HAWAIIAN/PACIFIC ISLANDER OTHER (SPECIFY) _____

FATHER: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

NAME: _____ OCCUPATION: _____

EDUCATION: LESS OR PARTIAL HIGH SCHOOL HIGH SCHOOL GRADUATE SOME COLLEGE BA/BS DEGREE

MOTHER: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

NAME: _____ OCCUPATION: _____

EDUCATION: LESS OR PARTIAL HIGH SCHOOL HIGH SCHOOL GRADUATE SOME COLLEGE BA/BS DEGREE

LIST IN CHRONOLOGICAL ORDER ALL SCHOOLS YOU HAVE ATTENDED

INSTITUTION

CITY

DATES ATTENDED

MAJOR _____

DEGREE/DATE GRANTED _____

INDICATE SCHOOL CURRENTLY ATTENDING AND PRESENT GRADE: _____

COLLEGE FRESHMAN COLLEGE SOPHOMORE

TEST SCORES: SAT: TOTAL _____ VERBAL _____ QUANTITATIVE _____
ACT: TOTAL _____ VERBAL _____ QUANTITATIVE _____

LIST HONORS RECEIVED (INCLUDING HONOR SOCIETIES) _____

LIST EXTRACURRICULAR AND COMMUNITY ACTIVITIES _____

LIST ANY RESEARCH EXPERIENCE _____

FIRST NAME MIDDLE NAME LAST NAME SCHOOL

EMPLOYMENT EXPERIENCE: (FULL/PART TIME)

EMPLOYER LENGTH OF EMPLOYMENT

LIST SCIENCE AND MATHEMATICS COURSES YOU EXPECT TO COMPLETE THIS SCHOOL YEAR:

COURSE TITLE FALL SEMESTER COURSE CREDIT COURSE TITLE SPRING SEMESTER COURSE CREDIT

HAVE YOU HAD COMPUTER TRAINING: YES NO

STUDENT AGREEMENT TO PARTICIPATE IN THE HEALTH PROFESSIONS PARTNERSHIP INITIATIVE PROGRAMS

I HEREBY (CONSENT/GIVE MY PERMISSION) TO PARTICIPATE IN THE HEALTH PROFESSIONS PARTNERSHIP INITIATIVE PROGRAMS. I UNDERSTAND THAT PARTICIPATION INCLUDES ATTENDANCE AT ALL SESSIONS OF THE REQUIRED ACTIVITIES OUTLINED IN PROGRAM DESCRIPTIONS, AND I FURTHER UNDERSTAND THAT THERE WILL ALSO BE PARTICIPATION IN FIELD TRIPS AND OTHER ACTIVITIES AWAY FROM THE SITE. I (WILL/GIVE PERMISSION) TO ATTEND THESE FUNCTIONS AND TO BE TRANSPORTED BY APPROVED BUSES UNLESS I GIVE WRITTEN WITHDRAWAL OF PERMISSION FOR A SPECIFIC EVENT. THE DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS IS GIVEN PERMISSION TO REPRODUCE FOR PUBLICATIONS ANY PHOTOS TAKEN AT PROGRAM FUNCTIONS.

APPLICANT SIGNATURE DATE

PARENT/GUARDIAN SIGNATURE DATE (PLEASE SIGN IF YOU ARE A PARENT OR GUARDIAN OF AN APPLICANT UNDER EIGHTEEN YEARS OF AGE)

FEDERAL FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

I HEREBY CONSENT TO THE DISCLOSURE OF STUDENT INFORMATION RECORDS MAINTAINED BY THE DEPARTMENT OF HEALTH CAREER OPPORTUNITY PROGRAMS AND/OR CAPITAL COMMUNITY COLLEGE. THIS INFORMATION WILL BE MAINTAINED IN A CONFIDENTIAL MANNER AND WILL BE USED ONLY FOR THE PURPOSES OF THE HCOP EVALUATION. USE IS CONSISTENT WITH THE FEDERAL FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, OR OTHER STATE OR FEDERAL LAWS, REGULATIONS, OR POLICIES. I UNDERSTAND THAT THIS PERMISSION MAY BE WITHDRAWN AT ANY TIME.

APPLICANT SIGNATURE DATE

PARENT/GUARDIAN SIGNATURE DATE (PLEASE SIGN IF YOU ARE A PARENT OR GUARDIAN OF AN APPLICANT UNDER EIGHTEEN YEARS OF AGE)

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ESSAY: TYPE OR WRITE (LEGIBLY) IN THE SPACE BELOW AN ESSAY DESCRIBING YOUR BACKGROUND, GOALS, MOTIVATION, SCIENCE CAREER INTERESTS, AND REASONS FOR WANTING TO PARTICIPATE IN THIS PROGRAM. IF NECESSARY, EXPLAIN ANY UNUSUAL ASPECTS OF YOUR PREPARATION AND/OR APPLICATION (USE ADDITIONAL SHEET(S) WITH YOUR NAME AND SOCIAL SECURITY NUMBER IF NECESSARY).

I CERTIFY THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE

PLEASE RETURN TO:

PAUL WHITEHEAD, A.B., M.SC., M.PHIL.

CAPITAL COMMUNITY COLLEGE

950 MAIN STREET, ROOM 909

HARTFORD, CONNECTICUT 06103

(860) 906-5215

PWHITEHEAD@CCC.COMMNET.EDU

OR

DANIELLE DALBON

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

FARMINGTON, CONNECTICUT 06030 – 3920

(860) 679-4545

BRIDGES@UCHC.EDU

WEBSITE: [HTTP://MEDICINE.UCHC.EDU/DEPARTMENTS/HCOP](http://medicine.uchc.edu/departments/hcop)