

Dear M * A * S * H Applicant:

The Medical Application of Science for Health (M * A * S * H) Program is a two week summer program for students who are **entering their sophomore, junior, or senior year of high school**. During this two-week program, students will become certified in Basic Life Support, First Aid, and learn the importance of healthy lifestyle habits. The basic science connections to medical diagnosis and treatment will be reinforced through lecture presentation, lab, and clinical interaction. Exposure to different areas of medicine and the health related professions is an integral part of the M * A * S * H experience. Students will learn to identify some of the various health care disciplines, what they do, how they relate to one another, and how the fundamentals of anatomy, biology, pharmacology, and physiology are employed in each discipline.

The M * A * S * H Program is sponsored and funded by North Arkansas Regional Medical Center, the University of Arkansas for Medical Sciences-Rural Hospital and the Farm Bureau. There is no charge to attend the program.

Students interested in participating in M * A * S * H must fulfill the following criteria:

1. Complete a biology course prior to their participation in M * A * S * H
2. Demonstrate scholastic ability measured by transcript and GPA (Minimum of 3.0)
3. Demonstrate the ability to be task committed and utilize creative and critical thinking skills
4. Submit a thoroughly completed application
5. Submit two (2) recommendations by school personnel (one must be from a science teacher)

The M * A * S * H Program will be held June 19 - June 30, 2006, at North Arkansas Regional Medical Center. If you want to attend the program and meet the requirements, submit the application and recommendation forms to:

North Arkansas Regional Medical Center
Mary Pledger, Education Services
620 N. Willow
Harrison, AR 72601

Students who are accepted into the M * A * S * H Program will be requested to submit documentation of TB test which has been completed since July 1, 2005.

Applications must be returned by April 17, 2006. Students will be notified by letter of the status of their acceptance into the program no later than May 1, 2006. If you have questions concerning this program, please call 870-365-2572. Thank you.

M * A * S * H STUDENT APPLICATION FORM

Please print clearly

1. Social Security Number: ___/___/___ Name: _____
(last, first, middle initial)

2. Sex: _____ Race: _____ Date of Birth: ___/___/___

3. Hometown Address: _____
(Street or P.O. Box) (City) (Zip Code) (County)

4. E-mail Address: _____

5. Nickname(s) (if you use any) _____

6. High School Name: _____ Year you graduate: _____

7. High School Mailing Address: _____
(Street or P.O. Box) (City)

8. Parent's Name: _____ Home telephone number: _____

9. Work telephone number: _____ Address: _____

10. T-shirt size: small medium large extra large

11. List your significant SCHOOL achievements, awards, & accomplishments of the past two years. (Please write neatly & accurately):

12. List your significant NON-SCHOOL (community, church, etc.) achievements of the past two years. Also describe any jobs or duties you have at home or school that demonstrate your level of commitment to a task.

(Continued on next page)

13. Please write in your own words why you are interested in attending M * A * S * H (Medical Application of Science for Health). Your response to this question is very important in the selection process. If you need more room, use one additional page and attach it to your application.

ACCEPTANCE STATEMENT

All your expenses for M * A * S * H are being paid by the Statewide Mentor Partnership. In addition, a \$50 scholarship will be contributed on your behalf by a community organization from your hometown. On the last day of M * A * S * H, your community sponsor will be invited to attend a luncheon with you and the other participants. You must agree to attend the full length of the program (2 weeks).

Please note that this is a day program and that transportation to and from each daily session is your responsibility.

Signed: _____ Date: _____
(Student)

PERMISSION STATEMENT

I hereby grant permission for my son/daughter to apply to this program and for school officials to report my child's achievement and grades. I understand that if my son/daughter is accepted, we will be responsible for his/her daily transportation for the two-week program.

Signed: _____ Date: _____
(Parent/Guardian)

M * A * S * H SCHOOL RECOMMENDATION FORM

**(INFORMATION FROM SCHOOL PERSONNEL ON STUDENT APPLYING FOR
M * A * S * H- CONFIDENTIALITY WILL BE HONORED)**

1. Student Name: _____
(First) (Middle) (Last)

2. School Name: _____ School District: _____

3. School Address: _____
(Street or P.O. Box) (City) (Zip Code) (County)

4. Attach a legible transcript of the student's grades to this form. Please include any citizenship grades.

Note: This student must have completed Biology in order to be considered for the M * A * S * H Program.

5. **TEACHER: THIS INFORMATION IS CONFIDENTIAL.** Please state why you think this student would benefit from participating in the M * A * S * H Program. Comments should be made regarding the student's abilities and potential for success in a health care environment. Use the space provided, then sign at the bottom of this page.

_____ Teacher's signature*

6. Include any additional information here from other faculty members that would assist the screening committee in making their selections.

ACADEMIC ENDORSEMENT

We have discussed pertinent information on this form with this student and agree that he/she is genuinely interested in participating in the M * A * S * H Program.

Counselor's signature*

Today's date

*** These signatures are required in order for the student to be considered by the selection committee.**