

M*A*S*H STUDENT APPLICATION FORM

All forms must be completed for applicant to be considered.

Please print clearly

1. Name: _____

2. Social Security Number: ____/____/____

3. Sex: _____ Date of Birth: ____/____/____ Age _____ Shirt Size _____

4. Address _____
(Street or P.O. Box) (Town) (Zip code) (County)

5. School Name: _____

6. Entering Grade: _____

7. Parent's name: _____

8. Home telephone number: _____ Cell phone: _____

9. Parents work number: _____

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

11. 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. (May continue on back of application if needed)

12. 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 the M*A*S*H program 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. If selected, you will be asked to send a letter to acknowledge the community organization that provided your scholarship. You must agree to attend for 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)

*Only twelve students will be accepted into the program. Letters of notification will be sent out the first week of May. If unable to attend, please notify us immediately so that an alternate can be chosen.

(School recommendation form must accompany application)

M*A*S*H SCHOOL RECOMMENDATION FORM

(INFORMATION FROM SCHOOL PERSONNEL ON STUDENTS APPLYING FOR M*A*S*H. WILL BE HELD IN THE STRICTEST CONFIDENCE.)

1. Student Name: _____

3. School Name: _____

4. School Address: _____
(Street or P.O. Box) (Town) (Zip Code) (County)

5. Attach a readable transcript of this student's grades to this form. Please include any citizenship grades.
Note: this student must have taken at least one science course in order to be considered for M*A*S*H.

6. TEACHER/COUNSELOR: THIS INFORMATION IS CONFIDENTIAL. Please state why you think this student would benefit from participating in M*A*S*H. 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/Counselor Signature _____

7. 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 _____ **Date** _____

Please return all completed forms to:

**White River Medical Center
Education Department
1710 Harrison Street
Batesville, AR 72501
Phone 870-262-1486
Fax 870-262-6533**