PHYSICIAN SHADOWING PROGRAM
UC IRVINE SCHOOL OF MEDICINE

Phone: 714.456.7509 E-mail: cfhp@uci.edu

2012 Student Application

Enrollment is limited to 10 students for this session, July 9th to July 23rd. The program is open to high school juniors and seniors and those entering college. Applicants must be at least 16 years of age. Applications are reviewed on a first-come basis and evaluated on the student's academic record, level of commitment to the program and a teacher recommendation letter.

Please type or print legibly and send or fax the completed application to:

Behnoosh Afghani, MD
UC Irvine Medical Center
101 City Drive, South, Bldg 26
Orange, CA 92868
Fax: 714.456.7182

The cost of the 2 week session is $2,350.

Students must provide their own transportation. But we can provide free parking.

Last Name: _____ First Name: _____ Middle Initial: __

Date of Birth: _____ Gender (circle): Male Female

Name of High School: _____ Student's Soc. Sec. #_____

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Address of High School: _____

High School Phone: _____Grade level: _____Current GPA: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home):_____Your Cell Phone: _____

Parent/Guardian Name: _____ Relationship to applicant: _____

Parent/Guardian Daytime Phone: _____Cell Phone: _____

Student's email _____

Parent/Guardian e-mail _____

Major hobbies and/or extracurricular activities _____

Please describe why you would like to join the Physician Shadowing Program (minimum of 100 words; use additional pages if needed):

To accept registration and permit participation in the Physician Shadowing Program by the above individual, I, the parent or guardian of said individual, hereby consent and agree to release, indemnify and hold harmless the University of California, the UC Irvine Physician Shadowing Program, its instructors and representatives from any claim arising from injury to the above named individual. We also hold harmless the University of California, the Physician Shadowing Program, its instructors and representatives from any claim arising from injuries or conditions caused or aggravated by our/my refusal to obtain available medical treatment on religious or philosophical beliefs.

I also give permission to reprint, without charge, any photographs or videos of myself or my child taken at during the Physician Shadowing Program. These photographs/videos may be published at a future date in various publications, such as brochures, websites or presentations related to the program. I recognize that I have no further claims on the author or publisher of these works.

Those students accepted to the program must complete online tutorials and registration materials prior to the start of session.

Signature of Student: _____Date: _____

Signature of Parent/Guardian: _____Date: _____

Parent/Guardian Name (Please print legibly):_____