

Stony Brook University, Faculty Committee on Health Professions  
E3310 Melville Library  
Stony Brook, NY 11794-3353  
Tel: 631-632-7080, Fax: 631-632-9259

## SIGNATURE PAGE

Please complete both parts of this form, **sign it**, and return a copy to us (via mail, fax, emailing of a scanned copy, or in person) at your earliest convenience.

### **I) I WILL BE APPLYING TO THE FOLLOWING PROFESSIONAL PROGRAM(S):**

*(Make sure to check off all programs that apply, and consult with your prehealth advisor regarding your choices. Please provide all applicable application service ID numbers.)*

- |   |                      |
|---|----------------------|
| <input type="checkbox"/> Allopathic Medicine (M.D.)           | (AAMC) AMCAS ID#:    |
| <input type="checkbox"/> Dental Medicine (D.D.S., D.M.D.)     | (ADEA) AADSAS ID#:   |
| <input type="checkbox"/> Foreign Medical School               |                      |
| <input type="checkbox"/> M.D./PhD. Combined Program           | also AMCAS ID#:      |
| <input type="checkbox"/> Optometry (O.D.)                     | (ASCO) OPTOMCAS ID#: |
| <input type="checkbox"/> Osteopathic Medicine (D.O.)          | (AACOM) AACOMAS ID#: |
| <input type="checkbox"/> Podiatry (D.P.M.)                    | (AACPM) AACPMAS ID#: |
| <input type="checkbox"/> Postbaccalaureate Enrichment Program |                      |
| <input type="checkbox"/> Veterinary Medicine (D.V.M.)         | (AAVMC) VMCAS ID#:   |

### **2) APPLICATION FILE WAIVER**

In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, P.L.93-380 (as amended), with specific reference to Section 438(a)(1)(B) and Subtitle A, sections 99.7, 99/11, and 99.12.

I  **DO**  **DO NOT** waive my right of access to a review of my application file and related materials. *(Please select either DO or DO NOT. Note: If you select DO, the file is confidential. If you select DO NOT, the file is not confidential.)*

Signature \_\_\_\_\_

First Name:

Last Name:

Date:

**Section 1: Basic Autobiographical Information**

Last Name	First Name	M.I.	Stony Brook ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last 4 Digits of Social Security #: <input type="text"/>	APPLICANT ID#(s): <input type="text"/>
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**ADDRESS & CONTACT INFORMATION:**

Legal Street Address	City	County	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Local Street Address	City	County	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Phone #	Campus Phone #	Cell Phone #	Email Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input style="background-color: yellow;" type="text"/>

**ADDITIONAL INFORMATION:**

Sex	Birth Date	Place of Birth	Citizenship	If not US citizen, specify visa type
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**PARENT(S) AND/OR GUARDIAN(S):**

Father's Name	Living?	Occupation	Legal Residence	Highest Degree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Mother's Name				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name(s) of Guardian(s) (if different from parents)				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**SIBLINGS AND AGES:**

Brother(s):
Sister(s):

**REAPPLICATION INFORMATION: Are you a reapplicant?**

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Year(s) applied: <input type="text"/>
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## Section 2: Admissions Test Scores and Academic History

**ADMISSIONS TESTS:** (check the tests that you have taken or plan to take)

<input type="radio"/> DAT	<input type="radio"/> GRE	<input type="radio"/> MCAT	<input type="radio"/> OAT	<input type="radio"/> Other(specify):
Indicate which test taken, date taken, and your score <b>on each section</b> :				
Indicate the test you plan to take and when:				
Did you or do you plan to take a review course to prepare for the admissions test?				

### HIGH SCHOOL:

Name of High School	City and State	Month and Year of High School Graduation
Sat Scores (include total math, verbal and total score):		

### COLLEGE ( list schools attended in chronological order):

Institution Name	City & State	Dates attended	Degree & date earned	# of credits earned

### COLLEGE/UNIVERSITY ACADEMIC HONORS AND AWARDS

Name of Award	Brief description of award	Date received

### GRADE POINT AVERAGES: (BCPM means Biology, Chemistry, Physics, and Mathematics courses)

	Number of credits	Grade Point averages
All Stony Brook courses		
Stony Brook BCPM Courses		
All courses from all institutions		
BCPM courses from all institutions		

**Section 3, Part 1:** Use the space provided below explain briefly how your academic record demonstrates that you are a competitive applicant who is capable of successfully completing a demanding course of study for your chosen profession.

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**Section 3, Part 2: Most Important Courses**

List the five science courses that are the best evidence of your ability as a science student, and list the five non-science courses that are the best evidence of your ability as a good reader, critical thinker, and student of the human condition.

Five Science Courses					Please use the space below to comment on one of your chosen courses.				
Course #	Course Title	Semester/ Year	Letter grade	# of Credits					
Five Non-Science Courses					Please use the space below to comment on one of your chosen courses.				
Course #	Course Title	Semester/ Year	Letter grade	# of Credits					





**Section 5: Health-Related Experience**

Please list all your health-related experiences **including high school**, preferably in chronological order, along with dates and contact information. Use additional sheets if necessary.

Hospital, Clinic, or Organization	Your Job, Position, or Role	Start Date mm/yy	End Date mm/yy	Hours per week (W) or total hours (T)	Supervisor	Supervisor 's phone number or email address for verification	Rank in order of importance: 1 <sup>st</sup> , 2 <sup>nd</sup> . . . last

Use this space to describe your health-related experiences.

**Section 6: Research Experience**

Please list all your research experiences, **including high school**, preferably in chronological order, along with dates and contact information. Use additional sheets if necessary.

Dep't/Institution	Research Topic	Start Date mm/yy	End Date mm/yy	Hours per week or total hours	Research Supervisor	Supervisor's phone number or email address for verification	Rank in order of importance: 1 <sup>st</sup> , 2 <sup>nd</sup> . . . . last

Use the space below to describe your research experiences.

Use the space below to describe your research experiences.



**Section 7: Qualitative Questions**

List significant books you have read, your hobbies, and/or travels, briefly explaining how they have influenced you:

Books:

Hobbies:

Travel:

What has been the most important factor contributing to your successes?

What has been the most important factor in whatever failures you have experienced?

**Disciplinary problems**, on campus or off, can be a source of worry for applicants. In some cases, the trepidation is justified. Nonetheless, admissions committees know that no one is perfect and that we can learn from our mistakes, thereby becoming stronger, better, more compassionate people. Use the space below to mention any infractions, on campus or off, and how they have changed you. Remember that many schools nowadays conduct background checks.

**Section 8: Additional Information and Personal Comments Essay**

**Additional Information**

Information about marital status and children is not required. It is intended to help the Committee learn more about you as an applicant and prepare a more personal letter of evaluation.

Marital Status	Name of Spouse

Names and ages of children:

**Places of Residence: (It is required that you list ALL your places of residence, both in and outside of the United States)**

Country	City	Dates	School, if enrolled

**Do you consider yourself to be economically or educationally disadvantaged?** Yes  No

If you are a member of one of the following racial/ethnic minorities underrepresented in the health professions, please check the group which applies to you.

Black American	Mexican American or Chicano	Native American/Innuait	Puerto Rican (Mainland)
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**Include any pertinent information that does not appear in the rest of your autobiographical packet.**

**\*FINAL TASK---In a separate document, write a personal statement that describes your background, your path through life, and how you know that your chosen profession is right for you.**