University of Arkansas for Medical Sciences

College of Health Related Professions 2013-2014 Physician Assistant Studies Application for Class Entering May 2013

PLEASE READ INSTRUCTIONS BEFORE STARTING APPLICATION

- Use curser to place text on form. You may use delete or backspace to erase text
- When application is completed select 'file', 'save as PDF and save to your computer
- When complete send application in an attachment to: <u>SchafferSusanS@uams.ed</u> <u>AND</u> <u>StilesMonnaL@uams.edu</u>

PERSONAL DATA		TO BE COMPLETED BY CHRP
		Submitted:
Name:		Completed:
Last First	Middle	Prev. Applied:
Nickname:		
Gender: Male ☐ Female ☐ Gender Variant ☐		ETHNICITY/RACE
Do not wish to report $\ \square$		☐Yes, Spanish/Hispanic/Latino/Latina
SSN#:		Please check all that apply below:
Date of Birth:		☐ Mexican, Mexican American, Chicano/Chicana
Month/Day/Year		□Cuban
State of Birth:		☐ Puerto Rican
County of Birth:		☐ South or Central American
Country of Birth:		☐ Other Spanish culture or origin
Citizenship Status:		If other, please specify:
What is your country of citizenship?		☐ Not Spanish/Hispanic/Latino/Latina
Do you hold a Visa? Yes ☐ No ☐		☐ American Indian or Alaska Native
Visa Type:		Please specify the name of your enrolled or principal tribe:
Indicate any language(s) other than English in which you	feel	, , , , , , , , , , , , , , , , , , , ,
comfortable conversing:		
In what state do you claim residency?		Please check all that apply below:
In what county do you claim residency?		☐Asian Indian
in what county do you claim residency!		☐ Cambodian
		□Chinese
SECONDARY (HIGH SCHOOL)		□Filipino
School Name:		□Japanese
City:		□Korean
State/Province:		□Malaysian
Year Graduated:		□Pakistani
		□Vietnamese
PREFERRED MAILING ADDRESS		☐ Other Asian
Address:		If other, please specify:
City:		Black or African American
State/Province:		□ Native Hawaiian or Pacific Islander
Country:		Please check all that apply below:
Zip:		☐ Guamanian or Chamorro
Telephone:		□ Native Hawaijan
Work Phone:		□Samoan
Mobile Phone:		☐ Other Pacific Islander
Email:		If other please specify:
		ii other piedse specify.
PERMANENT MAILING ADDRESS		 □White
Address:		- winte
City:		
Zip:		

Telephone:_

Do you consider your	self educatio	onally disadva	intaged?	∐Yes	∐No		
(By designating any of the below you are considered to have met the criteria for educational/environmentally disadvantaged as defined by the guidelines below.)							
□I graduated from a □I am from a family or I receive public a □I am from a family □I participated in an □I am a high school a □I am from a school	high school of that receives assistance. that lives in a academic er drop-out who district when ration in my f	at which man s public assist an area that is nrichment pro o received Ah re 50% or less family to atte age.	ny of the er ance (e.g., s designate ogram func dS diploma s of gradua nd college	Aid to Famed as a Head as a Head in whole or GED.	Ith Professional Shortage e or part by the Health Ca	or reduced lunches. dren, food stamps, Medicaid, public housing) Area or a Medically Underserved Area. areers Opportunity Program. ducation is not encouraged.	
CERTIFICATION/REGI	STRATION						
Highest Degree Earne	ed to Date						
Do you have any prof Do you have any prof			□Yes □ Yes	□No □No			
Do you have any prof	essional regi	istrations:	□ 163				
Type of Certification/	/Registratior	า	Date			Certifying/Registering Organization	
TEST RESULTS Please indicate below th	ne test(s) you l	have taken or p	olan to take				
	Taken f	Plan to Take	Date				
	iakeii i	Pidii to Take	Date				
GRE					GRE Scores Verbal:		
ACT/SAT						tative: cal:	
MCAT TOEFL					GRE Scores Arialytic	Lai	
AHPAT					MCAT Verbal Reaso	oning:	
TSE					MCAT Physical Scie	nces:	
				_	MCAT North a Common	iences:	
					ivica i writing sam	ple:	

BACKGROUND INFORMATION		
	Yes	No
Have you ever had any U.S. Military experience?		
Have you ever matriculated in or attended any PA education program?		
Were you ever disciplined for academic performance or conduct violations		
(e.g. academic probation, dismissal, suspension, disqualification, etc.) by any college of school?		
Have you ever been convicted of a felony or misdemeanor?		
Have you ever had any certification, registration, license, or clinical privileges revoked, suspended or		
in any way restricted by an institution, state or locality?		
If you answered Yes to any of the previous questions, please provide a brief explanation		
How you did first heard about the PA Profession/PA Education?		
Most influential factor in bringing you to the PA Profession/PA Education		

INSTITUTIONS ATTENDED

Name of Institution(s) Attended	Date Attended From	Date Attended To	Degree Earned	Additional Degree if any	Date Earned or Anticipated Mo/Yr	Degree Major	2 nd Major if Any	Minor if any

ACADEMIC AND PROFESSIONAL COURSEWORK

Please enter <u>all</u> coursework taken at all institutions attended. All grades must be recorded even if course was repeated and a higher grade resulted.

Institution	Semester	Year	Course Prefix	Course Title	Subject	Credits	Letter Grade
			_				
			_				

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Please enter <u>all</u> coursework taken at all institutions attended. All grades must be recorded even if course was repeated and a higher grade resulted.

Institution	Semester	Year	Course Prefix	Course Title	Subject	Credits	Letter Grade
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	1						
	1						
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	1						

DIRECT PATIENT CARE EXPERIENCE

Position Title:	
Employer:	
City:	
State:	
Supervisor:	
Start Date:	_
End Date:	_
Frequency:	_
Average Hours per week:	_
Hours accrued at time of application:	
Still currently at location?:	
Were you paid?	_
Employer telephone:	
Please describe your direct patient care duties and responsibilities:	
Position Title:	
Employer:	
City:	
State:	
Supervisor:	
Start Date:	_
End Date:	_
Frequency:	_
Average Hours per week:	_
Hours accrued at time of application:	
Still currently at location?:	
Were you paid?	_
Employer telephone:	_
Please describe your direct patient care duties and responsibilities:	
Position Title:	
Employer:	
City:	
State:	
Supervisor:	
Start Date:	-
End Date:	
Frequency:	_
Average Hours per week:	_
Hours accrued at time of application:	
Still currently at location?:	<u></u>
Were you paid?	

Employer telephone:			
Please describe your direct patient	care duties and responsibilities:		
Destates Tides			
Position Title:			
Employer:			
City:			
State:			
Supervisor: Start Date:			
Start Date: End Date:			
Average Hours per week:			
Hours accrued at time of applicatio	n:		
Still currently at location?:			
Were you paid?			
Employer telephone:			
Please describe your direct patient	care duties and responsibilities:		
CLIA DOMINO EVERENCE			
SHADOWING EXPERIENCE			
Name of PA or Physician	Area of Medicine	# Hours Shadowed	PA or Physician Phone #
Name of FA of Fnysician	Area of Medicine	π Hours Silauoweu	ra or rhysician rhone #

HEALTH RELATED TRAINING

Туре	Agency/School/Sponsor	Start Date	End Date	Did you receive a certificate?

PERSONAL NARRATIVE		
Please describe your motivation towards becoming a PA. t will expand to accommodate text.	Limit 5,000 characters, approximately 625 words.	Begin narrative in window an

REFERENCES (ONE REQUIRED FROM PHYSICIAN or PA, PROFESSOR, SUPERVISOR)

Name	Occupation

ADDITIONAL REQUIREMENTS NEEDED TO COMPLETE THE APPLICATION PROCESS:

- Please proof-read application before submitting
- When application is complete send in an attachment to: <u>SchafferSusanS@uams.edu</u> <u>AND</u> <u>StilesMonnaL@uams.edu</u>
- Complete the PA *Supplemental Application* also available on website. This application along with a \$40.00 fee will be submitted electronically.
- Print Reference Request Form for each letter of recommendation.
- GRE scores, official transcripts and letters of recommendation must be mailed to:

University of Arkansas for Medical Sciences CHRP Admissions Office 4301 West Markham, Slot 619 Little Rock, AR 72205-7199