Montefiore
THE UNIVERSITY HOSPITAL FOR ALBERT EINSTEIN COLLEGE OF MEDICINE

Montefiore's Health Opportunities Program (Monte-HOP)
Summer Internship Program
Application Deadline: April 17, 2015

Please read application package in its entirety.

Program Description: The Montefiore Health Opportunities Program (previously the Maternal & Child Health Program) is a stipend funded summer enrichment program for students from economically or educationally disadvantaged backgrounds and/or from groups typically considered underrepresented in the health care fields. The goal of the program is to promote, educate and encourage youth to pursue careers within the health fields. This program has been in existence since 2002 and has graduated over 171 students. Students will gain valuable knowledge and professional skills through interactive workshops, mentorship by health care professionals, observation of health care professional-patient interactions, lecture activities, formal presentations and independent learning.

Specific Program Activities:
-Participate in interactive-health related workshops (suturing, casting, etc…)

-Visit health-related organizations throughout New York City (ex: March of Dimes, Morris

- Heights Birthing Center, NYC Department of Health, etc…)

- Observe patient-health care professional interactions and gain knowledge about the medical interview

Develop and refine professional skills to pursue a career in a health-related field (ex. resume development, interviewing skills, written health paper, project presentation, etc…)

Eligibility Criteria: Must be…
1. Graduating High School Senior or College Freshman/Sophomore
2. A U.S. citizen or a Permanent Resident
3. From a group considered economically or educationally disadvantaged and/or from groups considered underrepresented in the health fields
4. Able to commute easily to all program/clinic sites (**housing is not available**)
5. Commit to participate in all activities of the program on a daily basis
   Formal program dates: July 6, 2015 through August 14, 2015
   Orientation: July 2, 2015, 9am-5pm
   July 6; regular full day
   Monday – Friday, 8am-5:30pm (a few sessions will run until 7pm)

*****Students selected for the program must be processed through Montefiore's Volunteer and occupational Health Departments (please see volunteer processing instructions).**

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Application Deadline: **April 17, 2015.** Interviews will be scheduled in May 2014.

All Mailed applications must be postmarked by April 17, 2015.

We highly encourage students to send all materials to complete their application package as soon as possible. Each year we have to turn many students away for incomplete packages. In addition, students who complete their applications in a timely fashion are much more likely to receive an interview. Please note an interview does not guarantee acceptance. Thank you.

Please mail application materials to:
Department of Family & Social Medicine, 2nd Floor
3544 Jerome Avenue Bronx, N.Y. 10467
Attention: Ms. Carol Whittaker, Program Manager
Email: cwhittak@montefiore.org; (718) 920-4678 (x6283)

Other contact: Deyanira Acevedo, Program Coordinator

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Application Checklist

**** You must complete this form and attach to the front of your application package. (or email as an attachment with your application package).**

_____ _____

Name of Student Date completed

_____ _____

School Name Preferred phone number

The following items MUST be completed and submitted prior to the application deadline. Please make sure to follow up with the Program Manager regarding the completion of your application package. It is the responsibility of the applicant to ensure that all materials are received prior to the stated deadline.

* The 2nd original passport photo must be mailed to the program manager if the application is submitted electronically.

Incomplete applications will not be reviewed.

	Completed	Documents Required
1	[ ]	Completed application checklist (this page)
2	[ ]	Completed **TYPED** application with 2 passport size photos – this helps us to remember applicants after interviewing
3	[ ]	1-2 Page Typed Essay
4	[ ]	Updated Resume
5	[ ]	2 Letters of Recommendation *(must be sent in sealed signed envelope)
6	[ ]	Signed Applicant Consent Form (must be signed by parent/guardian for students under 18 years of age)
7	[ ]	Consent for News Media Participation (must be signed by parent/guardian for students under 18 years of age; must also be signed by all students)
8	[ ]	Professionalism Contract (must be signed by parent/guardian and students)
9	[ ]	School Transcript (most recent showing at least last year's courses/grades) *Grades are not an official consideration for acceptance but are used to assist accepted applicants during educational planning for those who are accepted.

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Montefiore's Health Opportunities Program (Monte-HOP)

Application submission deadline: April 17, 2015 Program Dates: July 6,, 2015 through August 14, 2015

Instructions: Please complete all sections. All information will be kept confidential. All applications MUST BE TYPED into word document and returned to the Program Manager. Two letters of recommendation are required. Please email or mail all materials to the Program Manager, Ms. Carol Whittaker (see last page of application for contact information). Please make sure to call Ms. Whittaker to ensure your application materials have been received. You must attach the application checklist to the front of your application package.

Eligibility: This program is particularly tailored to promote the recruitment of persons from disadvantaged and underrepresented backgrounds into health care careers.

General Information

Printed on matte or glossy photo quality paper
2 x 2 inches (51 x 51 m

(tape photo)

Name:
Last First Middle Maiden

Date of Birth:

Current Address

Street: _____ _____ City: _____ State: _____ Zip Code: _____

Home phone:_____ Cell phone: _____ Email: _____

Email (list all): _____

Social Security Number: _____ Gender: _____

Permanent Address (Parent/Guardian/other relative): Name _____

Street: _____ City: _____ State:_____ Zip Code: _____

Parent(s) Contact Phone number: _____

Languages Spoken: _____ Fluency: _____

Emergency contact information: Name: _____ Relationship _____

Phone numbers: _____

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Education

Name of School: _____ Expected date of graduation: _____

Year in school: (check one): ____Graduating High School Senior
____ College Freshman ____ College Sophomore

School Address: _____ City:_____ State: _____ Zip Code: _____

GPA (cumulative) or Average: _____ Major: _____ Minor: _____

** If Graduating H.S. Senior, what college are you going to?: _____

Please explain any interruptions in your schooling: _____

_____

Are you a first generation student (First in your family completing High School or College): Yes _____ No _____

Citizenship (Please check one): U.S. ____ Permanent Resident ____

Background (Please check all that apply) Optional, but this information helps to assess who is applying to the program and what if anything needs to be done to enhance program outreach.

African American _____ Native American Indian _____ Hispanic/Latino _____ White _____ Asian/Pacific Islander _____

Other (Please specify) _____

Economic: What is your household income (combined income of all persons working in home to support family). This information is helpful in assessing which students qualify as economically disadvantaged and assists us in acquiring additional funds to continue students stipends: $ _____

Professional Interests What health career areas are you most interested in? (Please check all that apply)

Nursing _____ Medical Doctor _____ (Specialty: _____) Public Health _____ Podiatry _____

Pharmacy _____ Physical Therapy _____ Biomedical Research _____ Dentistry _____ Optometry _____

Chiropractor _____ Teaching _____

Other (Please specify) _____

Other (No need to repeat if on your resume, write 'On Resume')

Please list previous volunteer work and/or research experience:

List any honors, awards or certifications:

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Please list hobbies and/or interests:

How did you hear about the program?

_____

How long does it take for you to travel from your place of residence (where you'll be living during the program) to the two main program sites: (check using www.hopstop.com)

Montefiore Medical Center (111 East 210th Street, Bronx, NY, 10467) Time: _____

Albert Einstein College of Medicine (1300 Morris Park Avenue, Bronx, NY, 10461 Time: _____

How will you be traveling to the program sites?: (ie; bus, train, vehicle):

_____

Do you anticipate any challenges with traveling independently? If yes, please describe?: _____

_____

(All students applying to college must confirm orientation dates for college prior to completion of application period and inform the program of those dates. There are often many options for dates for orientations. If you are truly interested in this program please work with your school to choose a date that doesn't conflict with our program dates. Thank you.):

_____

_____

Required essay: Please describe the following: 1) why you are interested in applying to this program; 2) what particular health field you're interested in, if any, and why; 3) and how you think your participation in this program will help you achieve your short and long term personal and professional goals. Please have your essay reviewed by a mentor or advisor and insure essay is completed in a professional manner. Personal stories that relay your interests are often most telling. (Minimum 2 page essay)

Please return all application materials to:

Ms. Carol Whittaker, Program Manager
Department of Family & Social Medicine
Montefiore Medical Center
3544 Jerome Avenue, 2nd Floor
Bronx, NY 10467

Contact information:
718-920-4678 or 718-920-5521
Email: CWHITTAK@montefiore.org

Please contact Program Manager to ensure all materials have been received.

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Montefiore's Health Opportunities Program (Monte-H.O.P Letter of Recommendation (please print and give to evaluator)

Applicant's name: _____

Dear Evaluator,

This student has applied to the Monte-HOP Summer Internship. The Monte-HOP internship provides students with an opportunity to explore various health careers through interaction with health professionals. Students also engage in professional skill building activities and learn about important health issues affecting the community. ***This letter must come from a person with whom the student has established a professional or educational relationship with, not from a family member/friend/or friend of the family.***

Please return your recommendation in a sealed envelope. Please be as honest as possible. These recommendation letters are kept confidential and we want the students who would benefit the most from the program and who have the most serious interests in health care to have the opportunity to interview and be accepted. Thank you for your cooperation.

Evaluator's Name: _____

Title & Relationship to Student:_____

School Agency or Organization: _____

Address: _____

Phone: _____ Email Address:_____

Please answer the following questions about the applicant:

1. Explain why you feel this student would benefit from this opportunity?

2. In what ways does the student strive to meet his/her responsibilities?

3. How does this student stand out from other students?

Please check selection to indicate your recommendation for the applicant:

___Highly recommended ___Recommended ___Recommendation with reservations ___Not Recommended

** Any particular concerns/reservations:

_____

Signature: _____ Date: _____

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Application Consent Form

Application Deadline April 17, 2015

I understand that only completed applications returned to Monte-HOP and postmarked by the deadline, April 17, 2015, will be reviewed for consideration.

_____ _____
Signature of Applicant Date signed

I understand that there are limited internship positions available. I also understand that a completed application does not guarantee an interview and that an interview does not guarantee acceptance into the program.

_____ _____
Signature of Applicant Date signed

Program consent form: ALL students must sign one of the sections below (*Section B is for students in high school or under 18 years of age and requires parent/guardian signature).

Section A: Students 18 years and older

I, _____(Students Name) understand that if accepted into the program I will be expected to participate fully and professionally in various academic seminars, small group projects, hands on activities, observational shadowing activities in clinical environments, lectures and field trips, including but not limited to hospitals, health clinics and health professional schools. I also understand that I will be expected to travel independently by mass transit to various sites.

_____ _____ _____
(Print) Students Name (Signature) Student Date

_____ _____ _____
(Print) Parent/Guardian Name (Signature) Parent/Guardian Date

Section B: Students under 18 years

I, _____ (parent/ guardian) of _____(Students Name) authorize my child to participate in Monte HOP's six week Summer Internship. I understand that if my child is accepted into the program he/she will be expected to participate fully and professionally in various academic seminars, small group projects, hands on activities, observational shadowing activities in clinical environments, lectures and field trips, including but not limited to hospitals, health clinics and health professional schools. I also understand that my child will be expected to travel independently by mass transit to various sites.

_____	_____	_____
(Print) Students Name	(Signature) Student	Date
_____	_____	_____
(Print) Parent/Guardian Name	(Signature) Parent/Guardian	Date

***** Parent/Guardian signature required for those students under 18 years old**

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CONSENT AND RELEASE FOR USE OF IMAGES

I, _____, hereby agree to grant to Montefiore Medical Center and Albert Einstein College of Medicine of Yeshiva University, its successors and all persons acting under its permission or authority including, but not limited to, its employees and agents (collectively, "Montefiore and Einstein") permission to photograph, publish, reproduce, record and use photographs, motion pictures, videotapes or audio tapes (collectively referred to as "Images") of me (or my child, _____ [INSERT NAME]), in order to memorialize the medical care, surgery, any other procedures to be performed, my presence at Montefiore and Einstein facilities, and/or participation at Montefiore and Einstein events. The Images may be used for any and all purposes, including but not limited to distribution to the media, educational, promotional, publicity, advertising and fundraising purposes, as well as for possible publication by Montefiore and Einstein in various traditional and social media (e.g. Facebook) and on the internet. I acknowledge and agree that neither Montefiore nor Einstein will pay me (or my child) in any manner for such photographing/ recording and use of the Images. I grant this permission and release as a voluntary contribution and I waive any and all rights I(or my child) may have to royalties or other compensation in connection with any such publication or use. I hereby waive my right to inspect and/or approve the finished products and final usages. I hereby release and discharge Montefiore and Einstein from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form that may occur or be produced in the creation or processing of any images created by Montefiore and Einstein. The foregoing permission is granted for the entire time period during which I (or my child) receive(s) outpatient and inpatient treatment at Montefiore or Einstein and the right to use the Images shall continue until such time that the footage, photographs and other images are no longer used by Montefiore or

Einstein for educational, promotional, publicity, commercial and fundraising purposes. I also understand that I may contact my attending physician in writing to revoke future uses, but that my revocation will not affect disclosures of information that have already occurred. I understand that I am not required to sign this form authorizing the use of Images, and I may refuse to do so without any effect on my receipt of care at Montefiore.

I hereby release Montefiore Medical Center and Albert Einstein College of Medicine of Yeshiva University, its trustees, officers, employees, physicians, agents and assigns from any and all legal liability that may arise from any of the foregoing and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any of the foregoing.

Name (PRINT): _____ Signature: _____

Address: _____ Date: ____ / ____ / ____

Email address (optional): _____ Phone: _____

If Participant is a Minor:

Relationship: _____ Name: _____ Date of Birth: ____ / ____ / ____

Witness:

Name (PRINT): _____ Signature: _____ Date: ____ / ____ / ____

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Montefiore Medical Center's Health Opportunities Program (Monte-HOP)
Professionalism Contract

I, _____, agree that, if accepted to participate in the program, I will abide by the following professional code of ethics:

- To arrive on time to all activities and participate fully.
- To contact the coordinator or program manager immediately in case of emergency.
- To complete and submit high quality assignments in a timely fashion.
- To conduct myself in a professional manner at all times, i.e. attire & demeanor/behavior.
- To turn all electronic equipment off during the program (ie: phones, computers, beepers, etc…).
- To fully adhere and comply with all HIPAA guidelines as it relates to patient confidentially.
- To promptly notify the Program Director and Manager, as well as the program coordinators, of any issues that may limit my full participation in this learning experience.
- To enjoy, have fun and fully partake in all activities of the Montefiore Health Opportunities Program.

I, _____, verify that I have received and read the Montefiore Health Opportunities Program Manual. I agree to attend all planned sessions, five days of the week and to adhere to the dress code and expectations for professional behavior. I also agree to submit and present a well prepared public health project. I understand that if I am getting funded to participate in this program through a personal source (external funding) I will not receive stipend funding from Monte HOP. I further understand that I must complete the six week summer program satisfactorily (as detailed in above professional requirements) to receive the program stipend, if eligible. I am also aware that I may be dismissed from the program for non-compliance with above expectations or for missing 2 or more days from the program.

_____	_____	_____
Student Print Name	Student Signature	Date
_____	_____	_____
Print Name (Parent/Legal Guardian)	Parent/Legal Guardian Signature	Date

*** Parent/Guardian signature required for students who are under 18 years of age**