



MARQUETTE UNIVERSITY
HEALTH CAREERS OPPORTUNITY PROGRAM
 College Science Enrichment Program
 &
PRE-ENROLLMENT SUPPORT PROGRAM
 WEBSITE: <http://www.mu.edu/hcop>

INSTRUCTIONS: Please type or print clearly in black ink. Complete all sections of application. Our early acceptance date is **March 1, of current year.** We will continue to accept applications until **April 1.** Return the application to the addresses indicated at the end of the application. **In order to complete your packet please:** (1) send two letters of recommendation (mailed directly from each person making the recommendation, two must be from science instructors), (2) write an essay on why you want to participate, (3) include a copy of your parents 1040 or 1040A tax forms and, (4) send an official copy of your college transcripts. Official transcripts of all college level course work should be mailed to us directly from your institution. **Note:** You must be registered to attend college in the fall. Students with at least two semesters in biology and chemistry are highly preferred.

APPLICANT INFORMATION		
First Name:	Middle Initial:	Last Name:
Social Security #:	Date of Birth:	Gender: M / F
Current Address I WILL BE ADDRESS UNTIL ___/___/___		Permanent (Parent's) Address
Street Address:		Street Address:
City:		City:
State:	Zip:	State: Zip:
Area Code: Phone:	Area Code: Phone:	
Most frequently utilized e-mail address:		
CITIZENSHIP		
What city and state/country are you originally from? _____		
Citizenship: <input type="checkbox"/> US Citizen <input type="checkbox"/> Permanent Resident Alien # _____		
<input type="checkbox"/> Non-Resident Alien		
<i>If you are not a US citizen Proof of residency is required (i.e. driver's license, passport or immigration card)</i>		
ETHNIC/RACIAL IDENTITY		
<i>Please check one</i>		
<input type="checkbox"/> 1 = American Indian or Alaska Native	<input type="checkbox"/> 5 = Native Hawaiian or other Pacific Islander	
<input type="checkbox"/> 2 = Asian (Specify): _____	<input type="checkbox"/> 6 = White	
<input type="checkbox"/> 3 = Black or African American	<input type="checkbox"/> 7 = Unknown	
<input type="checkbox"/> 4 = Hispanic or Latino (Specify): _____	<input type="checkbox"/> 8 = Other (Specify): _____	
Do you have any Physical Disabilities that necessitates specifically designed instructional materials or programs, modified physical facilities, or related services to enable full participation in and access to the program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Specify:		
PROGRAM OF INTEREST		
<i>Please select one area of interest.</i>		
<input type="checkbox"/> Biomedical Sciences <input type="checkbox"/> Clinical Laboratory Sciences <input type="checkbox"/> Dentistry <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician Assistant Studies <input type="checkbox"/> Speech Pathology & Audiology		

ACADEMIC INFORMATION

Please list all colleges and universities attended.

1. Name of Current College/University:	City:	Zip Code:
State:	Minor:	
Major:		
Current Year in School: <input type="checkbox"/> FR <input type="checkbox"/> SO <input type="checkbox"/> JR <input type="checkbox"/> SR <input type="checkbox"/> Other	Expected Graduation Date (mo./year): ____/____/____	
Current GPA (Cumulative):	Current GPA (Science):	Grading Scale (Please Check): <input type="checkbox"/> 4.0 <input type="checkbox"/> Other:
Have you taken courses in biology or chemistry? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Name of College/University:	City:	Zip Code:
State:	Minor:	
Major:		
Current Year in School: <input type="checkbox"/> FR <input type="checkbox"/> SO <input type="checkbox"/> JR <input type="checkbox"/> SR <input type="checkbox"/> Other	Expected Graduation Date (mo./year): ____/____/____	
Current GPA (Cumulative):	Current GPA (Science):	Grading Scale (Please Check): <input type="checkbox"/> 4.0 <input type="checkbox"/> Other:
Did you take courses in biology or chemistry? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Name of College/University:	City:	Zip Code:
State:	Minor:	
Major:		
Current Year in School: <input type="checkbox"/> FR <input type="checkbox"/> SO <input type="checkbox"/> JR <input type="checkbox"/> SR <input type="checkbox"/> Other	Expected Graduation Date (mo./year): ____/____/____	
Current GPA (Cumulative):	Current GPA (Science):	Grading Scale (Please Check): <input type="checkbox"/> 4.0 <input type="checkbox"/> Other:
Did you take courses in biology or chemistry? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please list the biology or chemistry courses you have taken and/or are currently enrolled in:

Biology:

Chemistry:

EXTRA CURRICULAR ACTIVITIES

Please list any extracurricular activities you participate in below (sports, hobbies, clubs, etc.):

Have you ever participated in a health careers program (i.e. health club, internship/externship, mentoring)? Yes No

If yes, indicate the program name, sponsor, dates, city, and state below:

TEST SCORES

Please list scores and attach a copy of your score report to your application.

AHPAT

Have you taken the Allied Health Professions Admissions Test? Yes Date take? _____ No Date Planning? _____
Verbal _____ Quant. _____ Biology _____ Chemistry _____ Reading _____

DAT

Have you taken the Dental Admissions Test (DAT)? Yes Date taken? _____ No Date Planning? _____

Academic Avg. _____ PAT Avg. _____ Quant Reason. _____ Reading Comp. _____
Bio. _____ Inorganic _____ Organic _____ Sci. Avg. _____

Have you taken a DAT review course? Yes No If yes, where?

GRE

Have you taken the Graduate Record Examination? Yes Date take? _____ No Date Planning? _____

Verbal _____ Quant. _____ Analytical _____

PARENT INFORMATION

Father's / Guardian's Name:

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Did your father/guardian attend college? Yes No

Please check the highest level of degree obtained:

 Associate Degree Bachelor's Degree Master's Degree Doctoral Degree Other _____

Occupation:

Employer:

Mother's / Guardian Name _____

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Did your mother/guardian attend college? Yes No

Please check the highest level of degree obtained:

 Associate Degree Bachelor's Degree Master's Degree Doctoral Degree Other _____

Occupation:

Employer:

FAMILY INFORMATION

How many siblings do you have?

What is their range in age?

Have any of them attended college? Yes No If yes, how many?Have any attended graduate school? Yes No If yes, how many?Do you have any relatives in a health profession? Yes No What specific fields?

FINANCIAL INFORMATION

What is your parents' combined income as reported in the federal income tax form 1040 or 1040A for last year?
(Please enclose a copy) \$ _____**If you are an independent student what is your income as reported in the federal income tax form 1040 or 1040A for last year? (Please enclose a copy) \$** _____

HCOP OUTREACH

How did you hear about our program? Ad Counselor Friend Website Other _____

Please name the source/person:

Source's Address:

City:

State:

Zip:

REFERENCES

*List names and titles of two individuals who will complete your HCOP Recommendation Forms. Applicant must submit at least one academic recommendation (teacher or faculty). Please do not list relatives and friends as references.***Name**

Phone: ()

Title

Best time to contact:

E-mail address (optional)

Name

Phone: ()

Title

Best time to contact:

E-mail address (optional)

Name

Phone: ()

Title

Best time to contact:

E-mail address (optional)

PERSONAL STATEMENT

Please provide a short essay in which you introduce yourself. Explain why you want to participate in this program and why we should choose you as a participant. Attach your essay to the application.

VERIFICATION STATEMENT

I certify that the above information is true, complete and correct to the best of my knowledge. I understand that falsifying or providing incorrect information may jeopardize my participation in this or future Marquette University Health Careers Opportunity Programs.

Student Signature

Date

Parent/Guardian Signature (If student is under age 18)

Date

INFORMATION RELEASE

To be completed by the student:

I, _____, am applying for admission to Marquette University Health Careers Opportunity Program. I am aware of the provisions of the Family Educational Rights and Privacy Act and hereby authorize the release of the requested information directly to Marquette University Health Careers Opportunity Program (i.e. transcript, letters of recommendation, etc.). I realize that I may not view some of the information requested, for example, letters of recommendation. I understand that Marquette University will also maintain records of my performance in program activities. I agree to the release of this information to Marquette University staff members and the U.S. Department of Health and Human Services.

Student Signature

Date

Parent / Guardian Signature (If student is under age 18)

Date

Marquette University does not discriminate on the basis of race, national origin, gender age, religion or disability.

Please mail your form directly to the following addresses:

**Marquette University (1)
School of Dentistry**

Office of Multicultural Affairs/HCOP
801 West Wisconsin Avenue
Milwaukee, WI 53233
(414) 288-1533 or 1(800) 445-5385 ext. 2
(414) 288-5593 (FAX)
Multi@Marquette.edu (e-mail)

**Marquette University (2)
College of Health Sciences**

Health Careers Opportunity Program
P.O. Box 1881
Milwaukee, WI 53201-1881
(414) 288-5505
(414) 288-5987(FAX)
Muhcop@Marquette.edu (e-mail)

- (1) Interested in dental science program.
- (2) Interested in biomedical sciences, clinical laboratory science, physical therapy, physician assistant and speech pathology and audiology programs.