

Note: If your form is not editable in a browser window, please save to your computer and edit with [Adobe Acrobat Reader®](#) or comparable software.

UMKC School of Medicine - Allied Health Scholars Program Application

Applicant Information (please print or type)

Social Security number - Last 4 digits only _____ Last name _____ First _____ Middle _____ Maiden _____

Home phone _____ Work phone _____ Cell phone _____

Current legal address: number and street _____ City _____ State _____ ZIP _____ County _____

Current mailing address: number and street _____ City _____ State _____ ZIP _____ County _____

Date of birth _____ (00/00/000) Birth country _____ E-mail _____

Are you a Missouri resident? Yes No Place of birth _____ City _____ State _____ County _____

How long have you been a Missouri resident? _____

Are you a U.S. citizen? Yes No If no, country of citizenship _____

If resident alien, card number _____ Date of issue _____

Attach a copy of your card. **Note: If you are an international visa student (nonresident alien), you are not eligible to apply to the Allied Health Scholars Program.**

High school name _____ City / State _____ Grad. date _____

Optional Information

Gender _____ Are you Hispanic/Latino? _____
 Male Yes
 Female No

Which of the following do you consider to be your racial background? Place an "X" next to all that apply and a "P" on the line next to your primary race:

- ___ American Indian or Alaska Native
___ Asian (underrepresented)
___ Asian (includes Chinese, Filipino, Japanese, Korean, Asian Indian or Thai)
___ White
___ Black/African American
___ Native Hawaiian or Other Pacific Islander

Education Information

Colleges or universities attended: Please indicate all schools where you have been enrolled, regardless of status. Arrange to have official transcripts sent from each school you have attended to the UMKC School of Medicine Office of Admissions.

Name	Dates of attendance	Field of study	Degree/hrs. earned
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Cumulative grade point average (on 4.0 scale to date) _____ Anticipated college graduation date _____ (MM/YYYY)

Program Information

I am applying for the following program:

- Master of Science Anesthesia
 Master of Medical Science Physician Assistant

I am applying for the following term:

___ Spring 2020
___ Spring 2021

How did you find out about the Allied Health Scholars Program at UMKC? Please check where appropriate:

- ___ Brochure
___ Career counselors/Pre-med advisors
___ Internet
___ UMKC School of Medicine representative
___ Other (explain) _____

E-Consent

E-Consent for the School of Medicine selection process gives permission for the UMKC School of Medicine Office of Admissions to exchange e-mails with you regarding person-specific information. You have the right to receive your information in printed format. However, with your e-Consent, your transactions can be processed faster than if you have to wait for mail from our offices or conduct business in person. The choice is yours.

You must read and agree to the following information and conditions in order to complete the UMKC School of Medicine e-Consent process. You may withdraw your e-Consent at any time by sending a request to the UMKC School of Medicine Office of Admissions,

M1-103, 2411 Holmes St., Kansas City, MO 64108-2792.

If you do not consent, you should know that:

- All correspondence will be sent through the U.S. Postal Service, which may delay processing.
- No e-mail exchanges between you and staff of the School of Medicine Office of Admissions will be considered official.
- Even if you designate someone as authorized to access your information, no e-mail exchanges between that person and staff in the School of Medicine Office of Admissions will be considered official.
- All requests must be made in writing or in person.
- If your mailing address is not kept current with the University, you may experience significant delays.

Please check one and sign below:

- I give my e-Consent for the e-mail address confirmed here _____
 I do not give my e-Consent.

Date _____

Signature _____

STATEMENT OF STUDENT RESPONSIBILITY

I understand, as an applicant to the UMKC School of Medicine Allied Health Scholars Program, that it is my responsibility to verify that my application is complete by the appropriate deadlines. I am responsible for verifying that the School of Medicine has received all application materials necessary to complete my application, including the following: the School of Medicine Allied Health Scholars Program application; college and university transcripts; personal statement; résumé; shadowing experience verification form and at least three letters of recommendation. I understand that my application will remain incomplete until all of the above-mentioned materials have been received.

Date _____

Signature _____

Read carefully: I certify the information provided in and with this application is accurate and complete, and I understand that all required credentials and documents must be submitted before an admission decision can be made. I authorize the University of Missouri-Kansas City to maintain all my records under my signed name, and I understand these records and credentials in support of my application are the property of UMKC and may not be returned or reproduced.

Date _____

Signature _____