# Summer Research Scholar Program Application 2024

## Applicant Information

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| Full Name: | Click or tap here to enter text.      |  Click or tap here to enter text.     |   Click or tap here to enter text.    | Date: |  Click or tap to enter a date.     |
|  | Last | First | M.I. |  |  |

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| Address: | Click or tap here to enter text.      |    Click or tap here to enter text.   |
|  | Street Address (above) | Apartment/Unit # |

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|  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
|  | City (above) | State | ZIP Code |

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| Phone: | Click or tap here to enter text. | Email: | Click or tap here to enter text. |

## Education

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| Undergraduate Institution | Click or tap here to enter text. | Major: | Click or tap here to enter text. |

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| GPA overall: | Click or tap here to enter text. |

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| --- | --- |
| Graduation Date (Expected) (mm/yyyy) | Click or tap here to enter text. |

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| Medical School | Click or tap here to enter text. |

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| Graduation Date (Expected) (mm/yyyy) | Click or tap here to enter text. |

## Biographical Information

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| Date of Birth: (mm/dd/yyyy): | Click or tap here to enter text. | Country of Residence | Click or tap here to enter text. | Are you a U.S Citizen? | YES☐ | NO☐ |

|  |  |  |  |  |
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| If no, do you have a permanent resident status? | YES☐ | NO☐ | I-551 card number: | Click or tap here to enter text. |

Please send the following in PDF format via email to (carrie.little@atriumhealth.org) with the subject line **“ROSS SUMMER PROGRAM 2023”**:

1. **This completed application**
2. **Copies of all applicable transcripts** - Unofficial Only This is for processing of your application. If the document is locked, we are unable to review it properly.
3. **A personal statement** - please attach a PDF of your career goals and how you believe this program will help you accomplish those, with a 500-word maximum
4. **CV in PDF format listing the following:** academic honors, memberships, accomplishments, and any relevant experiences (e.g., previous work in the lab and/or clinic) with corresponding year(s) of involvement.

**If your forms are not sent in PDF format, your application may not be reviewed**

In addition to the above, **2 letters of reference** are required to be sent to carrie.little@atriumhealth.org. Please complete the information below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Letters will be sent by**:  |  | **Name** | **Title**  | **E-mail** | **Phone** |
| 1 |       |       |       |       |
| 2 |       |       |       |       |
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If you have any questions, please review the FAQ on the internship website, then send your questions to carrie.little@atriumhealth.org