Pre-Medical Access to the Clinical Experience (PACE) 2017

Student Application

CHECKLIST (For Your Own Use)

NOTE: Upon submission, all application materials will become the property of Stony Brook School of Medicine and will not be returned.

☐ Completed application forms (personal info, education history, extra-curricular activities, volunteer experience)

☐ Program personal statement

☐ Current health record. All vaccinations must be current. Failure to do so will result in immediate dismissal from the program

☐ Recommendation letters
  Note: Two letters of recommendation are required. One letter should be from science instructors/professors and the second can be from an individual of your choice.
  A current resume or curriculum vitae

☐ Sign all pages where required

ALL APPLICATION MATERIALS SHOULD BE SUBMITTED TO:

Inel J. Lewis, MPA
Program Director, SOM Diversity Initiatives
Pre-Medical Access to the Clinical Experience (PACE)
Stony Brook School of Medicine
SOM Dean’s Office
HSC Level 4, Room 4-170E
631.444.2866
Inel.lewis@stonybrookmedicine.edu

Your application must be postmarked and mailed by Friday, August 11, 2017

Remember, it is your responsibility to see that ALL application materials are postmarked and mailed by the deadline.

Program begins on Friday, October 6, 2017 and ends on Friday, November 17, 2017

Program Acceptance Notification is via email at Noon (est) on Friday, August 25, 2017
Pre-Medical Access to the Clinical Experience (PACE)

DESCRIPTION:

Pre-Medical Access to the Clinical Experience (PACE) is a six week program designed for third-year students who are interested in the field of medicine. The program prepares students to successfully navigate the medical school admission process, with activities including:

- Shadowing experience with Stony Brook SOM faculty in clinical and research settings, including Stony Brook Hospital and Mather Hospital (Port Jefferson)
- Individual Mentoring by Stony Brook School of Medicine Medical Students
- HIPPA training and certification
- KAPLAN MCAT Workshop
- Medical School Panel
- Hands-on Dissection Lab
- Medical School Admissions and Financial Aid Information
- End of program luncheon with medical students and faculty

Additionally, students are exposed to research, careers in medical education, and an in-depth review of medical career specialties. Each student is assigned to a medical student mentor, and there are formal and informal opportunities for participants to interact with School of Medicine faculty and staff.

PURPOSE:

The purpose of the Stony Brook School of Medicine Pre-Medical Access to the Clinical Experience (PACE) is to assist junior and senior level college and post-baccalaureate students through the admissions process for medical school. Program participants will also have an opportunity to increase their knowledge of career opportunities within medicine.

I. ELIGIBILITY

To participate in PACE, applicants must meet the following criteria:

- College junior from Stony Brook University
- Self-identify as a pre-medical student.
- Cumulative and science GPA of 3.0 or better.

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II. PERSONAL INFORMATION

1. Name: ________________________________________  LAST  FIRST  M.I.

2. Date of Birth: ______________________ Age: _____
   MONTH  DAY  YEAR

3. Birthplace ______________________

4. Citizenship: Applicants must be a US citizen or permanent resident to participate in the program (check one):
   ☐ US Citizen  ☐ Permanent Resident

5. Email Address: ______________________

6. Name of School: ______________________

7. Current Mailing Address: Current address until __________ / __________ / __________
   (PERSONAL/CAMPUS)
   STREET ________________________________  CITY, ST, ZIP
   Phone: (Room/Mobile) __________________________ / __________________________

8. Permanent Home Address:
   STREET ________________________________
   CITY, STATE ZIP CODE
   PHONE NUMBER __________________________

9. Please list the name and address of someone who will always know where you are at any point in the future:
   NAME __________________________  PHONE NUMBER __________________________
   STREET __________________________  CITY, ST, ZIP __________________________

10. Name of Parent or Guardian: ______________________________________

11. Phone Number: __________ / __________  11. E-mail: ______________________
    Land line  Cell Phone

12. Gender:  ☐ Female  ☐ Male  ☐ Other

13. Year in College: (circle one)  1  2  3  4

14. Lab coat size __________

15. Do you have transportation and a valid driver’s license? __________

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III. PROGRAM QUALIFICATIONS

☐ Socially disadvantaged: A student who comes from an environment that has inhibited (but not prevented) him or her from obtaining the knowledge, skills and abilities required to enroll in, and successfully complete an undergraduate course of study that could lead to a career in the health sciences. **This includes, but is not limited to:** First generation college students, students limited by their community setting (rural, inner city or reservation), students with a certified learning and/or physical disability, students from a single-parent household, or students from a foster-care setting for the majority of their K-12 experience.

☐ Demonstrated commitment to improving the health of the underserved and disadvantaged populations: Personal life experiences with underserved communities and/or experiences concerning disadvantaged health issues that have motivated you to pursue training in dentistry/medicine. Significant volunteer or other work for a clinic or agency serving the underserved or disadvantaged populations (local, national or international). Other experiences (e.g. specific courses taken) which have prompted you to focus on improving the health of underserved and disadvantaged populations.

I certify the information provided in this application is true to the best of my knowledge. If needed, I will supply information to document my status as a student from a disadvantaged background, or my demonstrated commitment to improving the health of underserved and disadvantaged populations.

Signature: ________________________________ Date: ____________________

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IV. FAMILY INFORMATION

Father
1. Name: ___________________________ ___________________________ ___________________________
   LAST FIRST M.I.

2. Occupation: __________________________

3. Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated

4. Education: □ Less Than/Partial High School □ High School Graduate □ Some College □ Associates Degree
   □ BA/BS Degree □ Graduate School □ Professional School (specify) __________________________

Mother
1. Name: ___________________________ ___________________________ ___________________________
   LAST FIRST M.I.

2. Occupation: __________________________

3. Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated

4. Education: □ Less Than/Partial High School □ High School Graduate □ Some College □ Associates Degree
   □ BA/BS Degree □ Graduate School □ Professional School (specify) __________________________

V. PERSONAL STATEMENT

Please provide a typed one-page (12 pt) personal statement in which you introduce yourself, and address the following questions:

1. What exposure have you had to the field of medicine and how has this influenced you?
2. What are your goals as a medical professional?
3. How would you describe yourself? How would others describe you?
4. Explain why you want to participate in this program and why we should select you as a participant.
5. What unique skills, qualities or life experiences would you bring to the medical profession?

Attach your typed personal statement to the application. Please save an electronic version of your answers to be used if you are accepted into the program. 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 any other future Stony Brook School of Medicine programs.

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VI. EDUCATIONAL HISTORY

Please list your high school and the most recent colleges or universities you have attended:

1. High School: ____________________________________________
   City: _____________________________ State: _______________ Zip: __________

2. Current College/University: ________________________________
   City: _____________________________ State: _______________ Zip: __________
   College Standing (circle one): Junior   Senior   Recent   College Graduate
   Major: ___________________________
   Total credit hours completed: _________ Cumulative GPA: __________

3. Name of College/University: ________________________________
   City: _____________________________ State: _______________ Zip: __________
   College Standing (circle one): Junior   Senior   Recent   College Graduate
   Total credit hours completed: _________ Cumulative GPA: __________

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Please list all **Biology, Chemistry, Physics, Math, English, Sociology and Psychology** course(s) you have taken and/or are currently enrolled. Include grade received, and semester/term you took the course. **Please be advised that all program pre-requisites must be fulfilled prior to the program in order to qualify for admission into the PACE Program. You must have received a 3.0 in your classes to qualify for this program.**

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<th>GRADE RECEIVED</th>
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**When do you plan to apply to medical school?** ________________________________

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Extra-Curricular Activities:
List any extracurricular activities (sports, hobbies, clubs, etc.). You may use a separate sheet of paper if necessary.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

How did you hear about our program?
☐ Friend
☐ Advisor
☐ Website
☐ Other: ________________________________

VII. REFERENCES

Two (2) letters of recommendation should be mailed directly from each person writing the recommendation. **Note:** One letter should be written by a science instructor and one letter may be written by an advisor, counselor, employer or other person of your choice.

List names and titles of the people you have asked to complete the 2 recommendation forms you received with your application. **Your references should include at least one science instructor and one non-science major.**

1.
Name
______________________________________________________________

Title
______________________________________________________________

Institution
______________________________________________________________

E-mail Address
______________________________________________________________

2.
Name
______________________________________________________________

Title
______________________________________________________________

Institution
______________________________________________________________

E-mail Address
______________________________________________________________
RECOMMENDATION FORM

Student’s Name: ____________________________

EVALUATOR:
The Stony Brook School of Medicine hosts a six-week program, Pre-Medical Access to the Clinical Experience (PACE), which is designed to expose participants to health careers in medicine for the purpose of developing competitive applicants for medical schools. Your candid and thoughtful evaluation of the applicant is greatly appreciated. Please return this completed form and attached letter of recommendation to the address below. Letters should be postmarked no later than Friday, August 11, 2017.

Please circle the number that corresponds to your evaluation of this applicant in the categories listed.

**Definition of Scale:**
1=Excellent  2= Very Good  3=Fair  4=Poor  X=Inadequate Knowledge

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<th>Category</th>
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Relationship to applicant? ____________________________________________

Within your recommendation letter, please describe the student’s qualities, characteristics, and if known, potential as a health care professional. Also, include any known academic weaknesses (test-taking, study skills, writing, etc.) to assist us in working with the student during the program.

Evaluator’s Name: ____________________________________________

______________________________  ________________________________
Evaluator’s Signature:            Date:

Please Return this Form to:
Pre-Medical Access to the Clinical Experience (PACE)
Attention: Inel J. Lewis, MPA
Stony Brook School of Medicine
SOM Dean’s Office
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RECOMMENDATION FORM

Student’s Name: ________________________________________________________________

EVALUATOR:
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Evaluator’s Name: __________________________ Position/Title: __________________________

PLEASE PRINT

Department: __________________________ School: __________________________

Evaluator’s Signature: __________________________ Date: __________________________

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