Dear Student:

Please complete the attached application by answering all questions to the best of your ability and as thoroughly as possible. Please note that all answers given on the student application portion must be completed in your own words. Feel free to type responses and use extra pages as necessary.

Give the form titled “M*A*S*H School Recommendation Form” to a teacher or counselor who can best evaluate your skill as a student and critical thinker. Ask this person to complete this form and return it to the address listed below (you may return it with your application or both pieces may be submitted separately). You must also see that one copy of your school transcripts is sent. If necessary, ask your teacher or counselor for the process of receiving these transcripts.

ONLY FULLY COMPLETED APPLICATIONS WILL BE ACCEPTED so be sure to follow-up that your teacher and/or counselor has completed all forms and that your transcripts have been mailed. You are also free to contact me, Andrea, at 501.686.5657 to verify that your entire application packet has been received.

Please note that the M*A*S*H program is open to students entering their junior or senior year of high school in the fall of 2008. All applicants must also have completed a biology course that will be reflected in your transcripts. M*A*S*H will occur June 9-20, 2008.

Please mail all applications to:
Andrea Stokes, Volunteer Coordinator
UAMS Medical Center
4301 W. Markham #527
Little Rock, AR 72205

For further questions, please contact me at the UAMS Medical Center Volunteer Services Department, 501.686.5657.

Thank you!
I look forward to reading your application!

Andrea C. Stokes
Volunteer Coordinator
UAMS Medical Center
Social Security Number: ___/___/____ Name: _______________________________________

(Gender: _______ Ethnicity (optional:______ Date of Birth: ____/____/____ T-shirt size______

Hometown Address: _________________________________________________________________

(Street or P.O. Box) (Town) (Zip code) (County)

Nickname(s) if you use any: ___________________________________________________________

Email Address: ______________________________________________________________________

Name of High School: __________________________ Year you graduate: ____________

High School Mailing Address: _________________________________________________________

(Street or P.O. Box) (Town) (Zip code)

Parent’s name: __________________________ Home Telephone number: ________________

Work telephone number: ____________ Address: _______________________________________

List your significant SCHOOL achievements, awards, & accomplishments (please write neatly &
accurately):

List your significant NON-SCHOOL (community, church, etc.) achievements. Also describe any
jobs or duties you have at home or school that demonstrate your level of commitment to a task.
Please write in your own words why you are interested in attending M*A*S*H (Medical Application of Science for Health.) *Your response to this question is very important in the selection process. If you need more room, use an additional page and attach it to your application.*

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**ACCEPTANCE STATEMENT**

All your expenses for M*A*S*H are being paid by the UAMS Medical Center Auxiliary. You must agree to attend for the full length of the program (2 weeks). Please note that this is a day program and that transportation to and from each daily session is your responsibility.

Signed: ___________________________ Date: ______________________
(Student)

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**PERMISSION STATEMENT**

I hereby grant permission for my son/daughter to apply to this program and for school officials to report my child’s achievement and grades. I understand that if my daughter/son is accepted, we will be responsible for her/his daily transportation for the two-week program.

Signed: ___________________________ Date: ______________________
(Parent/Guardian)

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*Please return completed form by April 1, 2008 to:*
Andrea C. Stokes, Volunteer Coordinator
UAMS Medical Center
4301 West Markham, # 527
Little Rock, AR 72205

*M*A*S*H Application Packet Page 3*
M*A*S*H SCHOOL RECOMMENDATION FORM
(All information from school personnel will remain confidential.)
(Please print clearly.)

1. Student Name ____________________________________________________________________

2. School Name: _______________________________ School District ________________________

3. School Address: __________________________________________________________________

4. Attach a readable transcript of this student’s grades to this form. Please include any citizenship grades. Note: this student should have taken a biology course in order to be considered for M*A*S*H.

5. Please state why you think this student would benefit from participating in M*A*S*H. Comments should be made regarding the student’s abilities and potential for success in a health care environment. Use the space provided or extra space as needed.
6. Include any additional information here from other faculty members that would assist the selection committee in making its selections.

ACADEMIC ENDORSEMENT

We have discussed pertinent information on this form with this student and agree that he/she is genuinely interested in participating in the M*A*S*H program.

_______________________________________    ________________________________________
School Representative/Teacher signature*        Today’s date

* These signatures are required in order for the student to be considered by the selection committee.

Please return completed form by April 1, 2008 to:
Andrea C. Stokes, Volunteer Coordinator
UAMS Medical Center
4301 West Markham, # 527
Little Rock, AR 72205