ARKANSAS RURAL HEALTH PARTNERSHIP
STUDENT MEDICAL INTERNSHIP APPLICATION

_____ _____

FIRST NAME: **LAST NAME**

_____/_____/_____ _____

DATE OF BIRTH **AGE**

_____

EMAIL ADDRESS

_____

CONTACT NUMBER

_____ _____

ADDRESS **CITY**

_____ _____

STATE **COUNTY**

_____

PARENT/GUARDIAN FULL NAME:

_____

PARENT/GUARDIAN EMAIL

_____

PARENT GUARDIAN CONTACT NUMBER:

NAME OF HIGH SCHOOL: _____

MOST RECENT GRADE COMPLETED: _____

_____ _____

CUMULATIVE GPA **HIGHEST ACT SCORE**

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PLEASE LIST ANY EXTRA-CURRICULAR ACTIVITIES, ACADEMIC CLUBS, LEADERSHIP ROLES, CIVIC AND SERVICE ORGANIZATIONS, SPORTS, ETC.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

COLLEGES INTERESTED IN APPLYING TO OR ATTENDING:

_____

_____

_____

COLLEGE MAJOR INTERESTS:

_____

_____

_____

HEALTHCARE FIELD INTEREST(S):

_____

_____

_____

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WHAT WOULD YOU HOPE TO LEARN FROM A REAL LIFE EXPERIENCE IN A HOPSTIAL?

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WHAT DOES IT MEAN TO YOU TO BE A HEALTHCARE HERO?

PLEASE ATTACH LETTER(S) OF RECOMMENDATION.