

PRIMARY CARE PHYSICIAN SHADOWING PROGRAM APPLICATION

Spring 2010

Print legibly. Please note that the Early selection deadline for Spring 2010 is *Friday, November 20, 2009*, and the Late selection deadline for Spring 2010 is *Monday, January 11, 2010*.

Return application and all other paperwork to:
Pre-Professional Advising
2500 Old Cafeteria Complex
East Carolina University
Greenville, NC 27858

For office use only:

Date received: _____

GPA: _____

Year in school: _____

Completion of biology course and lab: _____

Check if applicable:

___ MD/7

___ Degree in Three

___ Early Assurance

Verifier initials and dates:

PERSONAL INFORMATION

Name	
ECU ID	
Birth Date	
Local Address	
Local Home Phone Number	
Additional Phone Number (cell phone)	
ECU Email Address	
How did you hear about this program?	

ELIGIBILITY

Number of semesters you have completed in college, including community college work, (not including the current semester)	
Grade Point Average (* A 3.3 GPA is required at the time of selection as well as the semester you shadow.)	
Are you in the MD in seven years program?	
Are you in the Degree in Three program?	
Are you in the Early Assurance program?	

Applicant's last name: _____

Additional Information	
High School attended, city and state	
College attended, city and state	
Number of credit hours completed (not including the current semester)	
Course of study/major	
List completed college biology courses	
Are you registered with the PCMH Volunteer Center?	
Have you been convicted of or pleaded no contest to a felony within the last five years?	
If yes, please explain.	
Have you been convicted of, pleaded guilty to, or pleaded no contest to, an act of dishonesty, or breach of trust or moral turpitude, such as misdemeanor petty theft, burglary, fraud, and other related crimes within the last five years?*	
If yes, please explain. *Conviction of a crime, or pleading guilty to a criminal charge, will not necessarily disqualify you from the program.	

VOLUNTEER HISTORY	
List previous shadowing or volunteer experiences.	
Company name (or physician) City, State Company phone number Name of supervisor List dates	
Additional Volunteer Experiences:	

LEADERSHIP EXPERIENCE

Please list any leadership experiences that you have had in the past three years.

AVAILABILITY

Rank the days you are available to participate. #1=your top choice, #2=your second choice, etc.

**Please make note of the times and be sure you are able to shadow during the entire assigned time.*

Mondays	1:30p.m.-5:00p.m.	
Tuesdays	1:30p.m.-5:00p.m.	
Wednesdays	1:30p.m.-5:00p.m.	
Thursdays	1:30p.m.-5:00p.m.	
Fridays	1:30p.m.-5:00p.m.	

SELECT A FIVE-WEEK SESSION

Place a check next to the five-week session in which you would like to participate.

<input type="checkbox"/> 1st Five-week session Week of January 25 - Week of February 22	<input type="checkbox"/> 2nd Five-week session Week of March 15 - Week of April 12
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CONDITIONS OF ACCEPTANCE TO THE PROGRAM

The program has high standards for its participants, and compliance with these standards is a condition of participation in the program. Students are expected to represent East Carolina University in a positive manner upholding the following standards of professionalism:

- Representing ECU in a positive manner
- Arriving on time
- Maintaining a professional appearance by complying with the dress code and wearing a name badge at all times
- Smiling and making eye contact
- Maintaining a positive, enthusiastic attitude
- Treating others with respect
- Being honest and dedicated
- Following the Brody School of Medicine's policies and procedures
- Following directions
- Maintaining confidentiality
- Having a negative TB skin test

Applicant's last name: _____

- Showing proof of current health insurance
- Completing the HIPPA Privacy quiz and all other required paperwork

Are you willing and able to comply with all the requirements listed? __YES __NO

REFLECTION QUESTION

**Please write your response to this question in the space provided below or on a separate attachment.
Why do you wish to be a participant in the Primary Care Physician Shadowing Program?**

I agree that the information provided by me in this application is true, correct, and complete to the best of my knowledge. I understand that if selected for the program, any falsification, misstatement, or omission of fact in connection with my application, whether on this document or not, may result in immediate termination of participation. I authorize you to verify any and all information that I have provided.

Signature: _____ **Date:** _____

Printed name: _____