The MetroHealth Foundation
E. HARRY WALKER, M.D. SUMMER PRECEPTORSHIP IN COMMUNITY HEALTH
2024 APPLICATION FORM

PROGRAM REQUIREMENTS

Must be an Ohio resident OR attend an Ohio college or university
Must have completed two (2) years of undergraduate degree
The program runs from Monday June 3 through Friday July 26, 2024.

I. PERSONAL DATA

____
NAME: LAST FIRST M.I.

____
CURRENT ADDRESS: NUMBER STREET CITY STATE ZIP

____
HOME ADDRESS: NUMBER STREET CITY STATE ZIP

____
HOME TELEPHONE NO. SCHOOL TELEPHONE NO. E-MAIL ADDRESS

____
SOCIAL SECURITY NUMBER BIRTHDATE AVAILABLE STARTING DATE

II. EDUCATION

NAME ADDRESS DATES ATTENDED G.P.A. DEGREE MAJOR/MINOR

____
HIGH SCHOOL

____
*COLLEGE

____
*COLLEGE

____
*GRADUATE SCHOOL

____
*OTHER

COLLEGE AWARDS & HONORS:

____
____
____
____

***Please send official school transcript. (Page 1 of 2)**

PLEASE TYPE SECTIONS III. - VI. ON SEPARATE PAPER.
THERE ARE NO PAGE LIMITATIONS BUT PLEASE BE CONCISE.

III. EMPLOYMENT HISTORY

Please provide information covering your employment experience that would be relevant to this program (i.e., previous medical experience or volunteer experience). Include name of employer, dates, and a brief job description beginning with your most recent employment.

IV. GOALS

What are your long-range career goals?

V. OBJECTIVES

What objectives and accomplishments do you expect to achieve by participating in the E. Harry Walker summer Preceptorship in Community Health?

VI. PERSONAL INFORMATION

Please tell us any other information on your experience or abilities which you believe would assist us in evaluating your qualifications such as your interests, hobbies, recreational activities, affiliations, etc.

VII. RECOMMENDATIONS

Please arrange for two letters of recommendation from individuals with academic or previous volunteer work connections to be submitted.

MISCELLANEOUS

How did you hear of the E. Harry Walker summer Preceptorship in Community Health?

I hereby certify that all answers made on this application are complete and true to the best of my knowledge. I understand that any falsification would eliminate my application for consideration.

Print Name:____

Signature:____ Date:______________

Deadline is no later than MONDAY April 15, 2024

Students will be notified of results the week of April 28th, 2024

MAIL APPLICATION MATERIALS TO
MetroHealth Medical Center
Division of Med/Peds
Attention: Gail Smilnak
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998
If further information is needed, please contact Gail Smilnak
Phone: 216-778-2882 e-mail: gsmilnak@metrohealth.org

Remember this is a two-page application. If you were only given a one-page application, please ask your advisor for the second page or contact our offices and we can e-mail, fax or mail to you. Complete application is also available through our web site http://www.metrohealth.org. Look under education directory for site. Remember to include a completed application, TWO letters of recommendation, and official school transcript. These can be submitted all at once or separately by mail or e-mail.