The MetroHealth Foundation
THE EDWARD M. CHESTER, M.D. SUMMER SCHOLARS PROGRAM
2020 APPLICATION FORM

PROGRAM REQUIREMENTS

Must be an Ohio resident <u>OR</u> attend an Ohio college or university

Must have completed two (2) years of undergraduate degree

The program runs from Tuesday, May 26th through Friday, July 31, 2020.

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 TO	DATES ATTENDED FROM	G.P.A.	DEGREE	MAJOR/MINOR
HIGH SCHOOL						
*COLLEGE						
*COLLEGE						
*GRADUATE SCHOOL						
*OTHER						

COLLEGE AWARDS & HONORS:

***Please send official school transcript.**

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 laboratory or medical 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 Chester Summer Scholars Program?

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 <u>three</u> letters of recommendation from individuals with academic or previous scientific work connections to be submitted.

MISCELLANEOUS

How did you hear of the Chester Summer Scholars Program?

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.

_____

*Signature:*_____ *Date:*_____

Deadline is no later than FRIDAY, FEBRUARY 14, 2020

Students will be notified of results the week of March 16, 2020

MAIL APPLICATION MATERIALS TO
MetroHealth Medical Center
Division of Neonatology
Ground Floor, C Towers
Room: C.G88.
Attention: Cassandra Smith
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998
If further information is needed, please call Cassandra at 216-778-5946
e-mail: csmith1@metrohealth.org
fax: 216-778-3252

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, <u>THREE</u> letters of recommendation, and <u>official</u> school transcript. These can be submitted all at once or separately by mail or e-mail.