

The MetroHealth Foundation
E. HARRY WALKER, M.D. SUMMER PRECEPTORSHIP IN COMMUNITY HEALTH
2025 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 2 through Friday July 25, 2025.

I. PERSONAL DATA

NAME: LAST	FIRST	M.I.
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CURRENT ADDRESS: NUMBER	STREET	CITY	STATE	ZIP
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HOME ADDRESS: NUMBER	STREET	CITY	STATE	ZIP
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TELEPHONE NO.	SCHOOL TELEPHONE NO.	E-MAIL ADDRESS
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SOCIAL SECURITY NUMBER	BIRTHDATE	AVAILABLE STARTING DATE
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II. EDUCATION

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

*COLLEGE

*COLLEGE

*GRADUATE SCHOOL

*OTHER

COLLEGE AWARDS & HONORS:

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*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 28, 2025

Students will be notified of results the week of May 5th, 2025

MAIL APPLICATION MATERIALS TO
MetroHealth Medical Center
Division of Med/Peds
Attention: Jennifer Mocsiran
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998

If further information is needed, please contact Jennifer Mocsiran
e-mail: jmocsiran@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.