DEPARTMENT OF
Surgery
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

UW Department of Surgery
Clinical Research Internship for PEOPLE Students
Application Form – Summer 2017

Application Deadline: February 20, 2017

Instructions: Type or print in black ink all information requested on this application and return it by **February 12th** along with a) **biographical essay** as described in this application, b) **a photocopy or scan of original transcript**, and c) **one letter of recommendation** from a teacher. Recommendation letter may be sent separately but all other materials should be sent together. Upload all documents as one pdf file to www.surgery.wisc.edu/HS_Internship or send application materials to:

University of Wisconsin
Department of Surgery
Sarah Pavao
600 Highland Avenue
Clinical Science Center K6/160
Madison, WI 53792-7375
pavao@surgery.wisc.edu

Name: _____
(Last) (First) (Middle Initial)

Primary Mailing Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____ **Email Address**: _____
(Area Code) (Phone Number)

Date of Birth: _____ **Gender**: ☐ Male ☐ Female
(Month) (Day) (Year)

Ethnic Category: (check appropriate response)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Do Not Wish to Provide

Racial Category: (check appropriate responses)
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Do Not Wish to Provide

U.S. Citizen or Permanent Resident:

☐ Yes

☐ No

Student Academic Information

High School(s) Attended:

Current High School:

_____

(Name) (City) (State) (Zip Code) (Dates of Attendance)

_____

(Phone Number) Counselor's Name Principal's Name

Previous High School (if applicable):

_____

(Name) (City) (State) (Zip Code) (Dates of Attendance)

_____

(Phone Number) Counselor's Name Principal's Name

Current Grade Point Average: _____ (on a 4.0 scale)

Class Rank: # _____out of _____ (obtain this information from your transcript or high school counselor)

ACT: Composite Score _____ English _____ Math _____ Reading _____ Science _____

Anticipated Date of High School Graduation: Month _____ Year _____

If you have participated in any pre-collegiate programs other than the PEOPLE program, provide the name and location of the program(s) below:

_____

Student Academic Reference Information: Please indicate the teacher you have asked to write on your behalf. Your reference should know you sufficiently well to appraise your abilities.

Teacher: _____

(Name) (Phone Number)

Method of letter submission:

☐ Included with this application in a sealed school letterhead envelope

☐ Mail

☐ Electronic upload

Areas of Interest: Please indicate what type of career you are most interested in: _____

_____

Biographical Essay: On a separate sheet of paper please write a biographical essay (single-spaced, one inch margin, 12-point Times New Roman font, maximum of two pages) that addresses the following information:

- Brief personal and family background
- Educational background, including your academic strengths and weaknesses
- Extracurricular activities
- Reasons you are interested in the clinical research internship
- What you think makes you unique from other applicants of this program

- Your future educational and career goals

Parent/Guardian Information

Name of Father/Guardian: (Circle one and provide daytime phone numbers.)

_____

(Name) (Street) (City) (State) (Zip Code)

_____

(Occupation) (Employer)

_____

(Area Code/Daytime Phone Number) (Email Address)

Name of Mother/Guardian: (Circle one and provide daytime phone numbers.)

_____

(Name) (Street) (City) (State) (Zip Code)

_____

(Occupation) (Employer)

_____

(Area Code/Daytime Phone Number) (Email Address)

Contact person in case of emergency if parent/guardian cannot be reached:

_____

(Name) (Relationship to Participant) (Area Code/Daytime Phone Number) (Email Address)

The following statements and release must be signed by both the student and a parent or guardian.

Applicant Agreement: I understand that the Clinical Research Internship in the Department of Surgery has requirements and expectations that may go beyond other summer program opportunities. I acknowledge that satisfactory completion of the internship requires preparation outside of the standard daytime internship hours. If selected, I am willing to put my best effort forward to pursue a successful summer experience.
I further state that all statements are true to the best of my knowledge.

Signature of student _____ Date _____

Parent/Guardian Approval: If my child is accepted, I am willing to have my child participate in the 2016 UW Department of Surgery Clinical Research Program.

Signature of parent/guardian _____ Date _____

Application Checklist

If uploading application, please submit one .pdf document containing the application form, biographical essay, and a photocopy or scan of original transcript. The letter of recommendation can be emailed separately or uploaded to our website by your recommender.

If returning application via mail, all materials should be sent together in one envelope except the letter of recommendation):

☐ Application Form ☐ Biographical Essay ☐ A Photocopy or Scan of Original Transcript
☐ One signed letter of recommendation from a teacher (if submitted with this application, letter must be in a sealed school letterhead envelope from the recommender)

- Applicants will receive notification that their applications have been received. Any missing materials must be submitted by the application deadline
- Finalists will be selected and notified in early March.
- All finalists will be required to participate in a phone interview with members of the selection committee to be scheduled during the month of March.

To find out more about our program, please do not hesitate to visit our website at: http://www.surgery.wisc.edu/education-training/training-for-researchers/surgery-clinical-research-experiences-for-high-school-students/

Contact Sarah Pavao with any questions at 608-262-0744 or pavao@surgery.wisc.edu.