

MEDICAL SCHOLARS IN PUBLIC HEALTH (MSiPH) POSTBACCALAUREATE PROGRAM APPLICATION **2025**

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 **To submit your completed application prior to the deadline of March 13**

 **Please email the saved document as an attachment to Esimnachibia Thrower, MiSPH Coordinator, UAMS College of Medicine.**

 **Ethrower@uams.edu**

NAME

Last First Middle Initial

AMCAS ID NUMBER: UAMS GUS ID NUMBER:

CURRENT ADDRESS:

Street/Apt. No

City State Postal Code

HOME ADDRESS:

Street/Apt. No

City State Postal Code

UAMS COLLEGE OF MEDICINE ADMISSIONS STATUS FOR 2024 CYCLE:

Alternate List Not Accepted

**Most Recent MCAT score: \_\_\_\_\_\_\_\_\_\_\_ Date taken (month/ year): \_\_\_\_\_\_\_\_\_\_\_**

**Highest MCAT score: \_\_\_\_\_\_\_\_\_\_\_ Date taken (month/year): \_\_\_\_\_\_\_\_\_\_**

**Undergraduate Degree(s)/Majors** (For example: B.S. Biology or B.A. Psychology etc.)

1.

Minor:

Graduation

Month/Year

Institution: City/State

2. Minor: Graduation:

Month/Year

Institution: City/State

**Graduate Degree(s):** (M.S., MPH, PhD …. Etc.)

1. Degree and Program

Graduation:

Month/Year

Institution: City/State

1. Degree and Program Graduation:

Month/Year

Institution: City/State

# Your Contact Information:

Email Address:

Phone Number:

# REQUIRED APPLICATION QUESTIONS:

Please use the next pages to type your answers to the application questions for a maximum of 2 pages. The four questions you should address are listed below.

|  |
| --- |
| **QUESTIONS- PLEASE INCLUDE EACH QUESTION NUMBER 1-4 AT THE START OF EACH ANSWER** |
| 1) How do you hope to benefit from the Medical Scholars in Public Health (MSPH) postbaccalaureate program? |
| 2) Outline aspects of your prior application to medical school that need improving and list contributing factors, for example, working full-time etc. |
| 3) Provide personal reflections on your motivation to pursue medicine and on how public health may enhance your career. |
| 4) Address the issue of cultural sensitivity in health care training programs and subsequent patient interactions during medical school and residency. |

**Date**

**Applicant Name** (Your typed name will be your signature )

**By signing this form, I attest that all information is true and accurate and I am responsible for notifying the University of Arkansas for Medical Sciences, College of Medicine, Office of Admissions of any changes which might affect residency status. I grant permission to members of the MSPH committee full access to my most current AMCAS application.**

# ESSAY ON FOLLOWING PAGES:

