Montefiore’s Health Opportunities Program (Monte-HOP)
Summer Internship Program
Application Deadline: April 18, 2014

Please read application package in its entirety.

Program Description: The Montefiore Health Opportunities Program (previously the Maternal & Child Health Program) is a stipend funded summer enrichment program for students from economically or educationally disadvantaged backgrounds and/or from groups typically considered underrepresented in the health care fields. The goal of the program is to promote, educate and encourage youth to pursue careers within the health fields. This program has been in existence since 2002 and has graduated over 130 students. Students will gain valuable knowledge and professional skills through interactive workshops, mentorship by health care professionals, observation of health care professional-patient interactions, lecture activities, formal presentations and independent learning.

Specific Program Activities:
- Participate in interactive-health related workshops (suturing, casting, etc…)
- Visit health-related organizations throughout New York City (ex: March of Dimes, Morris Heights Birthing Center, NYC Department of Health, etc…)
- Observe patient-health care professional interactions and gain knowledge about the medical interview

Eligibility Criteria: Must be…
1. Graduating High School Senior or College Freshman/Sophomore
2. A U.S. citizen or a Permanent Resident
3. From a group considered economically or educationally disadvantaged and/or from groups considered underrepresented in the health fields
4. Able to commute easily to all program/clinic sites (housing is not available)
5. Commit to participate in all activities of the program on a daily basis
   Formal program dates: June 30, 2014 through August 8, 2014
   Orientation: June 30th, 9am-5pm
   July 1st - 3rd; regular full day
   July 4th (off for holiday)
   Monday – Friday, 8am-5:30pm (a few sessions will run until 7pm)

***Students selected for the program must be processed through Montefiore’s Volunteer and occupational Health Departments (please see volunteer processing instructions).

Application Deadline: April 18, 2014. Interviews will be scheduled in April 2014.
All Mailed applications must be postmarked by April 18, 2014 and all emailed must be sent by 11:59PM on due date.

We highly encourage students to send all materials to complete their application package as soon as possible. Do not wait until close to deadline. Each year we have to turn many students away for incomplete packages. In addition, students who complete their applications in a timely fashion are much more likely to receive an interview. Please note interview does not guarantee acceptance. Thank you.

Please mail application materials to:
Department of Family & Social Medicine, 2nd Floor
3544 Jerome Avenue Bronx, N.Y. 10467
Attention: Ms. Carol Whittaker, Program Manager
Email: cwhittak@montefiore.org; (718) 920-4678 (x6283)

Other contact: Deyanira Acevedo, Program Coordinator
Application Checklist

** You must complete this form and attach to the front of your application package. (or email as an attachment with your application package).

____________________________                         ______________
Name of Student                                                                       Date completed

___________________________                                           ___________________
School Name                                                                            Preferred phone number

The following items MUST be completed and submitted prior to the application deadline. Please make sure to follow up with the Program Manager regarding the completion of your application package. It is the responsibility of the applicant to ensure that all materials are received prior to the stated deadline.

* The 2nd original passport photo must be mailed to the program manager if the application is submitted electronically.

Incomplete applications will not be reviewed.

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<tr>
<th>Completed</th>
<th>Documents Required</th>
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<tbody>
<tr>
<td>1</td>
<td>[ ] Completed application checklist (this page)</td>
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<tr>
<td>2</td>
<td>[ ] Completed <strong>TYPED</strong> application with 2 passport photos (<strong>emailed applications require passport photo’s be mailed</strong>) – this helps us to remember applicants after interviewing</td>
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<tr>
<td>3</td>
<td>[ ] 1-2 Page Typed Essay</td>
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<td>[ ] Updated Resume</td>
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<td>5</td>
<td>[ ] 2 Letters of Recommendation *(must be sent in sealed signed envelope)</td>
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<tr>
<td>6</td>
<td>[ ] Signed Applicant Consent Form (must be signed by parent/guardian for students under 18 years of age)</td>
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<tr>
<td>7</td>
<td>[ ] Consent for News Media Participation (must be signed by parent/guardian for students under 18 years of age; must also be signed by all students)</td>
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<tr>
<td>8</td>
<td>[ ] Professionalism Contract (must be signed by parent/guardian and students)</td>
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<tr>
<td>9</td>
<td>[ ] School Transcript (most recent showing at least last year’s courses/grades)</td>
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*Grades are not an official consideration for acceptance but are used to assist accepted applicants during educational planning for those who are accepted.
Montefiore’s Health Opportunities Program (Monte-HOP)

Application submission deadline: April 18, 2014            Tentative Program Dates: June 30, 2014 through August 8, 2014

Instructions: Please complete all sections. All information will be kept confidential. All applications MUST BE TYPED into word document and returned to the Program Manager. Two letters of recommendation are required. Please email or mail all materials to the Program Manager, Ms. Carol Whittaker (see last page of application for contact information). Please make sure to call Ms. Whittaker to ensure your application materials have been received. You must attach the application checklist to the front of your application package.

Eligibility: This program is particularly tailored to promote the recruitment of persons from disadvantaged and underrepresented backgrounds into health care careers.

General Information

Name: _________________________________________________________
     Last                           First                         Middle                  Maiden

Date of Birth: __________________

*Place 2nd passport photo in small envelope and staple one to this page

Current Address

Street: ________ ___________________________ City: ____________   State: ________  Zip Code: ___________
Home phone:_____________________   Cell phone: ______________________  Email: _____________________________
Email (list all): ______________________________________________________________________________________

Social Security Number: _______________________________    Gender:   _______

Permanent Address (Parent/Guardian/other relative): Name _______________________________________________
Street: _______________________________________     City: ____________  State:_________   Zip Code: ___________
Parent(s) Contact Phone number: ____________________________________

Languages Spoken: ___________________________________   Fluency: _______________________

Emergency contact information: Name: ___________________________________   Relationship _____________
Phone numbers: ____________________________________________
**Education**

Name of School: ____________________________       Expected date of graduation: ______________

Year in school: (check one): ____Graduating High School Senior
 ____ College Freshman          ____ College Sophomore

School Address: _________________________________________  City:___________  State: _____  Zip Code: ________

GPA (cumulative) or Average: __________________      Major:  _______________________    Minor: ________________

** If Graduating H.S. Senior, what college are you going to?: __________________________________________________

Please explain any interruptions in your schooling: ___________________________________________________________

____________________________________________________________________________________________________

Are you a first generation student (First in your family completing High School or College):   Yes _____     No _____

Citizenship (Please check one):        U.S.  ____          Permanent Resident  ____

Background (Please check all that apply)  Optional, but this information helps to assess who is applying to the program and
what if anything needs to be done to enhance program outreach.

African American _____    Native American Indian _____    Hispanic/Latino _____     White _____     Asian/Pacific Islander

Other (Please specify) ________________________________________________________________________________

Economic:  What is your household income (combined income of all persons working in home to support family).  This
information is helpful in assessing which students qualify as economically disadvantaged and assists us in acquiring additional
funds to continue students stipends:  $ ____________________________

Professional Interests   What health career areas are you most interested in? (Please check all that apply)

Nursing _____    Medical Doctor _____   (Specialty: ________________________)    Public Health _____    Podiatry _____

Pharmacy _____    Physical Therapy _____  Biomedical Research _____  Dentistry _____  Optometry _____

Chiropractor _____  Teaching ______

Other (Please specify) ________________________________________________________________________________

Other   (No need to repeat if on your resume, write ‘On Resume’)

Please list previous volunteer work and/or research experience:

List any honors, awards or certifications:

Please list hobbies and/or interests:
How did you hear about the program? 
__________________________________________________________________________________________________

How long does it take for you to travel from your place of residence (where you’ll be living during the program) to the two main program sites: (check using www.hopstop.com)

Montefiore Medical Center (111 East 210th Street, Bronx, NY, 10467) Time: _______________

Albert Einstein College of Medicine (1300 Morris Park Avenue, Bronx, NY, 10461) Time: _______________

How will you be traveling to the program sites?: (ie; bus, train, vehicle): 
_________________________________________

Do you anticipate any challenges with traveling independently? If yes, please describe?: ______________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

(All students applying to college must confirm orientation dates for college prior to completion of application period and inform the program of those dates. There are often many options for dates for orientations. If you are truly interested in this program please work with your school to choose a date that doesn’t conflict with our program dates. Thank you.):
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Required essay: Please describe the following: 1) why you are interested in applying to this program; 2) what particular health field you’re interested in, if any and why; 3) and how you think your participation in this program will help you achieve your short and long term personal and professional goals. Please have reviewed by a mentor or advisor and ensure essay is completed in a professional manner. Personal stories that relay your interests are often most telling. (Minimum 2 page essay)

Please return all application materials to:
Ms. Carol Whittaker, Program Manager
Department of Family & Social Medicine
Montefiore Medical Center
3544 Jerome Avenue, 2nd Floor
Bronx, NY 10467

Contact information:
718-920-4678 or 718-920-5521
Email: CWHITTAK@montefiore.org

Please contact Program Manager to ensure all materials have been received.
Montefiore’s Health Opportunities Program (Monte-H.O.P)  
Letter of Recommendation

Applicant’s name: ________________________________________________

Dear Evaluator,

This student has applied to the Monte-HOP Summer Internship. The Monte-HOP internship provides students with an opportunity to explore various health careers through interaction with health professionals. Students also engage in professional skill building activities and learn about important health issues affecting the community. *This letter must come from a person with whom the student has established a professional or educational relationship with, not from a family member/friend/or friend of the family.*

Please return your recommendation in a sealed envelope. Please be as honest as possible. These recommendation letters are kept confidential and we want the students who would benefit the most from the program and who have the most serious interests in health care to have the opportunity to interview and be accepted. Thank you for your cooperation.

Evaluator’s Name: ________________________________________________

Title & Relationship to Student: ____________________________________

School Agency or Organization: ____________________________________

Address: _________________________________________________________

Phone: __________________________ Email Address: ___________________

Please answer the following questions about the applicant:

1. Explain why you feel this student would benefit from this opportunity?

2. In what ways does the student strive to meet his/her responsibilities?

3. How does this student stand out from other students?

Please check selection to indicate your recommendation for the applicant:

___ Highly recommended  ___ Recommended  ___ Recommendation with reservations  ___ Not Recommended

** Any particular concerns/reservations:

__________________________________________________________________________

Signature: ____________________________________________ Date: _____________
Application Consent Form

Application Deadline April 18, 2014

I understand that only completed applications returned to Monte-HOP and postmarked by the deadline, April 18, 2014 (11:59 PM on 4/18/14 for Electronic applications), will be reviewed for consideration.

__________________________________________    __________________________
Signature of Applicant                                                                Date signed

I understand that there are limited internship positions available. I also understand that a completed application does not guarantee an interview and that an interview does not guarantee acceptance into the program.

__________________________________________    __________________________
Signature of Applicant                                                                Date signed

Program consent form:    ALL students must sign one of the sections below (*Section B is for students in high school or under 18 years of age and requires parent/guardian signature).

Section A: Students 18 years and older

I, __________________________________________ (Students Name) understand that if accepted into the program I will be expected to participate fully and professionally in various academic seminars, small group projects, hands on activities, observational shadowing activities in clinical environments, lectures and field trips, including but not limited to hospitals, health clinics and health professional schools. I also understand that I will be expected to travel independently by mass transit to various sites.

_______________________________              _________________________________        _________
(Print) Students Name                                        (Signature) Student                                                    Date

_______________________________              _________________________________        _________
(Print) Parent/Guardian Name                          (Signature) Parent/Guardian                                      Date
**Section B: Students under 18 years**

I, ________________________________ (parent/ guardian) of _____________________ (Students Name) authorize my child to participate in Monte HOP’s six week Summer Internship. I understand that if my child is accepted into the program he/she will be expected to participate fully and professionally in various academic seminars, small group projects, hands on activities, observational shadowing activities in clinical environments, lectures and field trips, including but not limited to hospitals, health clinics and health professional schools. I also understand that my child will be expected to travel independently by mass transit to various sites.

________________________________________  ________________________________  _________
(Print) Students Name                                        (Signature) Student                                                    Date

________________________________________  ________________________________  _________
(Print) Parent/Guardian Name                          (Signature) Parent/Guardian                                      Date

*** Parent/Guardian signature required for those students under 18 years old ***
CONSENT AND RELEASE FOR USE OF IMAGES

I, _________________________________, hereby agree to grant to Montefiore Medical Center and Albert Einstein College of Medicine of Yeshiva University, its successors and all persons acting under its permission or authority including, but not limited to, its employees and agents (collectively, “Montefiore and Einstein”) permission to photograph, publish, reproduce, record and use photographs, motion pictures, videotapes or audio tapes (collectively referred to as “Images”) of me (or my child, __________________________ [INSERT NAME]), in order to memorialize the medical care, surgery, any other procedures to be performed, my presence at Montefiore and Einstein facilities, and/or participation at Montefiore and Einstein events. The Images may be used for any and all purposes, including but not limited to distribution to the media, educational, promotional, publicity, advertising and fundraising purposes, as well as for possible publication by Montefiore and Einstein in various traditional and social media (e.g. Facebook) and on the internet. I acknowledge and agree that neither Montefiore nor Einstein will pay me (or my child) in any manner for such photographing/ recording and use of the Images. I grant this permission and release as a voluntary contribution and I waive any and all rights I(or my child) may have to royalties or other compensation in connection with any such publication or use. I hereby waive my right to inspect and/or approve the finished products and final usages. I hereby release and discharge Montefiore and Einstein from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form that may occur or be produced in the creation or processing of any images created by Montefiore and Einstein. The foregoing permission is granted for the entire time period during which I (or my child) receive(s) outpatient and inpatient treatment at Montefiore or Einstein and the right to use the Images shall continue until such time that the footage, photographs and other images are no longer used by Montefiore or Einstein for educational, promotional, publicity, commercial and fundraising purposes. I also understand that I
may contact my attending physician in writing to revoke future uses, but that my revocation will not affect disclosures of information that have already occurred. I understand that I am not required to sign this form authorizing the use of Images, and I may refuse to do so without any effect on my receipt of care at Montefiore.

I hereby release Montefiore Medical Center and Albert Einstein College of Medicine of Yeshiva University, its trustees, officers, employees, physicians, agents and assigns from any and all legal liability that may arise from any of the foregoing and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any of the foregoing.

Name (PRINT): _________________________________ Signature: ___________________________
Address: __________________________________________________________ Date: ____ / ____ / ____
Email address (optional): ____________________________________________ Phone: ___________________

If Participant is a Minor:
Relationship: ________________ Name: _______________________ Date of Birth: ____ / ____ / ____

Witness:
Name (PRINT): ____________________ Signature: ___________________ Date: ____ / ____ / ____
Montefiore Medical Center’s Health Opportunities Program (Monte-HOP)

Professionalism Contract

I, ____________________________, agree that, if accepted to participate in the program, I will abide by the following professional code of ethics:

- To arrive on time to all activities and participate fully.
- To contact the coordinator or program manager at least one hour or more before any planned activity if I will be absent or late.
- To complete and submit high quality assignments in a timely fashion.
- To conduct myself in a professional manner at all times, i.e. attire & demeanor/behavior.
- To turn all electronic equipment off during the program (i.e.: phones, computers, beepers, etc…).
- To fully adhere and comply with all HIPAA guidelines as it relates to patient confidentiality.
- To promptly notify the Program Director and Manager, as well as the program coordinators, of any issues that may limit my full participation in this learning experience.
- To enjoy, have fun and fully partake in all activities of the Montefiore Health Opportunities Program.

I, ______________________________, verify that I have received and read the Montefiore Health Opportunities Program Manual. I agree to attend all planned sessions, five days of the week and to adhere to the dress code and expectations for professional behavior. I also agree to submit and present a well prepared public health project. I understand that if I am getting funded to participate in this program through a personal source (external funding) I will not receive stipend funding from Monte HOP. I further understand that I must complete the six week summer program satisfactorily (as detailed in above professional requirements) to receive the program stipend, if eligible. I am also aware that I may be dismissed from the program for non-compliance with above expectations or for missing 2 or more days from the program.

__________________________                 ____________________________              ____________
Student Print Name                                     Student Signature                                          Date

______________________________        _______________________________         ___________
Print Name (Parent/Legal Guardian)          Parent/Legal Guardian Signature                  Date

* Parent/Guardian signature required for students who are under 18 years of age