BLYTHEVILLE MASH APPLICATION AND INFORMATION

STUDENTS: PLEASE KEEP THIS SHEET FOR YOUR RECORDS

Hello!

As the M*A*S*H* Program Director for the Blytheville program, I want you to know we are excited about your interest in a health career and your desire to enhance your knowledge and gain experience within this field. Thank you for taking the time to seriously consider this program from UAMS as you make plans for the summer. Students are selected based on GPA, an essay describing their desire to attend M*A*S*H, recommendation letters, extra-curricular activities and community service, as well as awards and accomplishments. A committee made up of faculty from various Allied Health programs at Arkansas Northeastern College will review all applications and assist in the selection process. Please take the time to have a teacher proofread your application for any misspelled words or mistakes. If you have questions, please feel free to email me at any time. If you don't have an email address, create one, but make sure it sounds professional. ALL students who apply will be notified by mail of their status by **May 8.** If you have not received a letter by then, please contact me.

If you are not sure what to expect, below is a little information about our camp. I look forward to reading over your applications and learning more about you!

Kyra Langley MSN, RN, CNS
M*A*S*H Program Director - Blytheville
klangley@smail.anc.edu
870-598-7914

M*A*S*H*, or Medical Applications of Science for Health, is a two-week summer camp that introduces high school students in the 10th or 11th grade to health careers. Students selected into the M*A*S*H* program will shadow in a variety of health care locations, learn medical terminology, take part in hands on activities to learn medical procedures, as well as a tour of local hospitals and colleges to learn more about the opportunities in our area! Students also take part in team building activities, heart dissection and suturing, proper wrapping techniques and casting, as well as learning about a variety of health careers and education levels needed for different careers. It's too much to list, but we cover a lot over these two weeks!

Students accepted are required to attend Monday-Friday, 8-4:30 pm. Breakfast, lunch, and snacks are provided. This program is located at Arkansas Northeastern College in Blytheville. We do not provide transportation or housing for this program. Students selected should make arrangements for their own transportation.

This is a **FREE** program for students, thanks to community donations, support from the M*A*S*H Partnership and Farm Bureau. If you have any questions, please give us a call!

M*A*S*H
Medical Applications of Science for Health

Camp Location: ANC Nursing & Allied Health Building, Blytheville, AR

PROGRAM DATES: JUNE 15 – 25, 2020

DEADLINE TO APPLY: March 18, 2020

STUDENT INFORMATION

Please print clearly

STUDENT:

1. Name:_____
Last *First* *Middle initial*

2. Gender (circle): Male / Female

3. Race (check one):
- □ White
- □ Black/ African American
- □ American Indian or Alaska Native
- □ Asian
- □ Hispanic
- □ Native Hawaiian or Pacific Islander
- □ Other: Please specify: _____

4. Date of Birth: _____/_____/_____
Month *Day* *Year*

5. Do you go by a different name on a daily basis? If so, what is it? _____

6. Home Address: _____
Street or P.O. Box

_____
City *State* *Zipcode*

7. Home phone number: _____ Student Cell phone number: _____
Area code/number (xxx) xxx-xxxx *Area code/number (xxx) xxx-xxxx*

8. E-mail address: _____
(If you don't have one, create one. This will be used to contact you about your status/acceptance into the program.)

CONTINUED: STUDENT INFORMATION

9. Name of High School: _____

10. Year You Will Graduate: _____

11. Currently I am in the _____ grade.

12. School Mailing Address: _____
(Street or P.O. Box) *(Town)*

13. T-shirt Size (circle one): S M L XL 2X

14. What health career (s) are you MOST interested in? _____

15. Please list any food allergies or dietary restrictions you have: _____

16. Do you have any medical conditions, including pregnancy, we should be aware of? □ Yes □ No

*If yes, please specify: _____

*Please note: For your safety, we ask that you tell us about any medical conditions. This information will NOT disqualify you from the program.

17. Have you participated in M*A*S*H before? (at any location, not just Jonesboro) □ Yes □ No

18. Have you applied to any M*A*S*H programs before? □ Yes □ No

19. Have you applied, or planning to apply, to any other M*A*S*H programs this year? □ Yes □ No

*If yes, please specify the which program(s): _____

20. Choice of job shadowing site:
Please rank the following sites from 1 to 10, 1 being your top choice and 10 your least favorite.
Make sure you rank 10 sites total!

___ CRITICAL CARE NURSING
___ DENTIST
___ FAMILY PRACTICE PHYSICIAN
___ GERIATRICS
___ LABOR/DELIVERY
___ OPTHALMOLOGY (eyes)
___ OTOLARYNGOLOGY (Ear, Nose, Throat)
___ PEDIATRICS
___ PHARMACY
___ THERAPY (Speech, Physical, Occupational)
___ RADIOLOGY
___ VETERINARY MEDICINE
___ SURGERY/ANESTHESIOLOGY

If you do not see an option listed, please write in the area you would want to shadow this will be considered your #1 unless you specify otherwise.

SPECIAL REQUEST: _____

PARENT or GUARDIAN Information

21. Parent Name_____

22. Home Address: _____

_____

23. Home/Work phone number: _____ Cell phone number: _____
Area code/number *Area code/number*

******These are required in case of emergency.***

STUDENT WRITING SECTION

24. List your significant SCHOOL activities, achievements and awards of the past two years:
(Please write neatly. Attach another sheet of paper if necessary.)

25. List your significant NON-SCHOOL (community, church, etc.) achievements of the past two years. Also describe any jobs or duties you have at home or school that demonstrate your level of commitment to a task. (Attach another sheet of paper if necessary).

STUDENT WRITING SECTION

26. Please write, in your own words, why you are interested in attending M*A*S*H (Medical Application of Science for Health) and why you want to learn about health careers. Your response to this question is very important in the selection process. If you need more room, attach another page to your application.

DISCIPLINARY POLICY

M*A*S*H faculty and staff aim to maintain a safe, positive, and educational environment for all participants. Certain behaviors can result in your immediate dismissal from the M*A*S*H program and the notification of your parent/guardian. These behaviors include, but are not limited to:

- Deliberate violation of host facility's safety rules
- Possession of alcohol and/or illegal drugs
- Being intoxicated or under the influence of any controlled substances
- Use of tobacco products or e-cigarettes during program hours
- Violation of dress code or cell phone policy
- Inappropriate language or discussions
- Violation of HIPAA rules and regulations
- Harmful or inappropriate contact or communication with other participants and/or staff
- Deliberate destruction or damage to property
- Unexcused tardiness or absence

STUDENT ACCEPTANCE STATEMENT

All your expenses for M*A*S*H are being paid by the M*A*S*H Partnership, which includes Arkansas Farm Bureau, UAMS, ANC and local sponsors. If accepted into the program, you agree to attend the full length of the program (2 weeks) and to abide by the disciplinary policy. **Please note this is a day program and that transportation to and from each daily session is your responsibility.**

Signed: _____ **Date:** _____
(Student)

PARENT/GUARDIAN PERMISSION STATEMENT

I hereby grant permission for my son/daughter to apply to this program and for school officials to report my child's achievement and grades. I understand that if my son/daughter is accepted, we will be responsible for his/her daily transportation for the two-week program.

I also acknowledge that if my child is selected for this program, he/she is required to have proof of a negative TB skin test provided by our PCP (primary care provider). This is NOT a service provided by ANC.

Signed: _____ **Date:** _____
(Parent/Guardian)

M*A*S*H SCHOOL RECOMMENDATION FORM

STUDENTS: You are required to have at least 2 teachers write recommendations for you and the counselor's endorsement, including your transcript. You may also seek other letters of recommendation from community members, employers, youth pastors, etc.

(CONFIDENTIALITY WILL BE HONORED REGARDING INFORMATION SUPPLIED BY SCHOOL PERSONNEL)

Recommendation #1

1. Student Name _____
(First) (Middle) (Last)

2. School Name:_____ School District_____

3. School Address_____
(Street or P.O. Box) (Town) (Zip Code) (County)

4. TEACHER: THIS INFORMATION IS CONFIDENTIAL. Please state why you think this student would benefit from participating in M*A*S*H. Comments should be made regarding the student's abilities and potential for success in a health care environment. Use the space provided or attach your letter, then sign at the bottom of this page.

_____ _____
Teacher's signature Today's date

Printed Teacher Name _____

Email _____

What subject do you teach? _____

Recommendation #2

1. Student Name _____
(First) (Middle) (Last)

2. School Name:_____ School District_____

3. School Address_____
(Street or P.O. Box) (Town) (Zip Code) (County)

4. TEACHER: THIS INFORMATION IS CONFIDENTIAL. Please state why you think this student would benefit from participating in M*A*S*H. Comments should be made regarding the student's abilities and potential for success in a health care environment. Use the space provided or attach your letter, then sign at the bottom of this page.

_____ _____
Teacher's signature Today's date

Printed Teacher Name _____

Email _____

What subject do you teach? _____

SCHOOL COUNSELOR ACADEMIC ENDORSEMENT

Student Name _____
(First) (Middle) (Last)

I have discussed pertinent information on this form with this student and agree that he/she is genuinely interested in participating in the M*A*S*H program. Based on my professional opinion, I agree this student will behave and conduct him/herself in an appropriate and professional manner.

_____ _____
Counselor's signature Today's date

_____ _____
Counselor's Printed Name Counselor's Email

Student's Cumulative GPA _____ Student's ACT Score _____

Attach a legible transcript for this student. Please include any citizenship grades or comments or ACT scores. ** Note: this student must have taken BIOLOGY (or be currently enrolled) in order to be considered for M*A*S*H.

PLEASE MAIL COMPLETED APPLICATION, TRANSCRIPT (MUST INCLUDE CUMULATIVE GRADE POINT AVERAGE**) AND SIGNED CONSENT FORMS BY MARCH 18, 2020 TO:**

ANC - BLYTHEVILLE M*A*S*H PROGRAM
C/O KYRA LANGLEY
2501 S. DIVISION ST.
BLYTHEVILLE, AR 72315

M*A*S*H
Medical Applications of Science for Health

Confidentiality and Hold Harmless Agreement (Minor)

As the undersigned parent(s) or legal guardian(s) of _____, a minor child, I (We) hereby consent to the participation of said child in a volunteer program and tour at the University of Arkansas for Medical Sciences (UAMS) or other associated Hospital or Facility through the volunteer program. I (We) understand and agree that said child is to abide by all rules and requirements requested by UAMS and to conduct herself/himself in an appropriate manner.

I (We) understand that in the course of the child's participation in this program and tour, he/she may have incidental exposure to confidential information. Confidential information includes all patient, employee, and student information and information of a proprietary, trade secret or otherwise confidential nature. I (We) agree that, during the child's participation in the program and after the conclusion of the program, said child will not disclose the confidential information to anyone, including myself/ourselves, in any way or in any form without the specific written authorization of UAMS except as may be required by law.

I (We) hereby consent to and expressly authorize the release of said child's name, hometown and the name of the school said child attends while child is participating in the program. I acknowledge that UAMS may release this information to stakeholders of the M*A*S*H* Programs, Arkansas Colleges and Universities, and others UAMS deems necessary to further the program. I acknowledge that this is a limited release of confidential student information under the Family Educational Rights and Privacy Release Act ("FERPA").

I (We) understand that there are certain risks inherent to and associated with the activities of any facility in which patient care and research are conducted. I (We) agree on behalf of said child to the assumption of those risks and to not hold the University of Arkansas or its officers, board members, agents or employees responsible for any harm or injury from any cause, which may befall said minor child related to or arising out of the child's participation in the program and/or tour of UAMS or associated facility or hospital and hereby release said entities and persons from any liability relating thereto. I (We) further agree to indemnify and hold said entities and persons harmless from the claims or causes of action asserted by any other person on behalf of said child, or in their own right, arising out of said participation. I (We) similarly agree to hold said entities and persons harmless from the claims of other persons arising out of any acts done by said child. I (We) understand and agree that this Agreement is not intended to include a release from harm caused by an individual's criminal conduct or by the conduct of an individual constituting an intentional tort recognized under Arkansas law; and any such criminal conduct or intentional tort is against UAMS policy and therefore outside the scope of the person's employment or relationship with UAMS for which UAMS is not vicariously liable. I (We) agree that these conditions and agreements are binding on all of my (our) heirs, executors, administrators, representatives, assignees and successors in action.

I (We) have read and understand the above and willingly agree to said terms and conditions. This authorization was signed voluntarily with the express understanding that this release will allow access by certain individuals to limited student information about said child that participates in this program.

Signature _____ Date: _____

State relationship to child: _____

Signature _____ Date: _____

State relationship to child: _____

Parental/Guardian(s) Consent for Student Participation in M*A*S*H*

Name of Child: _____ Date of Birth: _____

I understand that if my child has been selected to participate in the Medical Applications of Science to Health (M*A*S*H*) Program at ANC - BLYTHEVILLE I hereby give my permission for my child to participate in this program. I agree to execute the Confidentiality and Hold Harmless Agreement and to make my child aware of his/her responsibilities included in the Agreement. _____ Initial

I am aware that regular attendance at the M*A*S*H* Program and adherence to both ANC - BLYTHEVILLE and UAMS policies and procedures will be required of my child. _____ Initial

I authorize ANC - BLYTHEVILLE and UAMS to release my child's name, hometown and the name of the school my child attends while participating in the M*A*S*H Program to certain stakeholders of the program, Arkansas Colleges and Universities and others as they deem necessary to further promote the program. _____ Initial

I understand that it is my child's responsibility to become familiar with orientation materials. _____ Initial

I give my permission for my child to participate in a Cardiopulmonary Resuscitation (CPR) course which may include a risk of physical strain, the possibility of cross infection, or emotional stress. If my child has a medical history that may be aggravated by this course, I will consult his/her physician to determine if my child should participate in the CPR course. _____ Initial

I understand that various departments and clinical services at ANC - BLYTHEVILLE and Great River Medical Center may allow my child to observe and participate in available and appropriate activities. _____ Initial

I consent to and authorize ANC - BLYTHEVILLE and UAMS to use my child's photograph for education and public relations purposes related to the M*A*S*H* Program. _____ Initial

I am aware that my child will be expected to follow instructions, to be punctual, to be courteous, and to avoid unsafe acts. This will include respecting confidentiality, following a specified dress code, and refraining from using a cell phone during the program. I understand that violations of these rules may result in dismissal of my child from the program. _____ Initial

Please sign after you have read and initialed all the above statements.

_____ _____

Print Name Relationship to Child

_____ _____

Signature Date

Photography Release Agreement

I, the undersigned, hereby give the University of Arkansas for Medical Sciences, their legal representative, assigns, and those acting on their behalf and with their permission, the right and permission to copyright in any part of the world, to use, reuse, publish and republish, in conjunction with my own or fictitious name, any photograph, film or video tape recording taken of me by the University of Arkansas for Medical Sciences or those acting on their behalf or with their permission, and any reproductions thereof, in any form, whether intentional or otherwise, and may be used in conjunction with any advertising material, for any purposes of trade, advertising, exhibit, publicity, or promotion, without restriction or limitations. I understand that the photographs, film and/or video may be used in news releases, newspapers or magazine articles, television, the UAMS website or social media sites (e.g., Facebook, YouTube).

I hereby release, discharge, and agree to save harmless the University of Arkansas for Medical Sciences, their assigns, legal representatives, agents, and those acting on their behalf and with their permission, from and against any liability resulting from any distortion, blurring, alteration or use in composite form, whether such was intentional or otherwise, which my occur, result, or be produced in the taking of said photography, or by processing or reproduction of the finished product, its publication or the distribution of same.

I waive the right to approve or inspect the recordings, advertising copy, or material used in conjunction therewith.

I hereby warrant that I have read this agreement in its entirety before affixing my signature thereto, and I fully understand the contents therein. I further warrant that I am of legal age and competent to contract my own name as far as the above is concerned.

DATE _____

PRINT NAME _____ SIGNATURE_____

I warrant that I am the parent and/or guardian of:

PRINT NAME _____
the person named in the foregoing Release Agreement, and that I am duly authorized to act in his/her behalf. I have read the foregoing agreement in its entirety and I understand its contents. I hereby consent that the photography taken under this agreement may be used for the purposes set forth therein.

DATE _____

PRINT NAME _____SIGNATURE _____