4730 Riverdale Road, Suite 3, Memphis, TN 38141 901. 758. 2127 (phone) 901. 758.2297 (fax) www.determinedtobeadoctorsomeday.org

September 1, 2017

Dear High School Student:

Congratulations! You've been given this information because you have excelled in the classroom and demonstrated promise as a future doctor. I can tell you first-hand, coming from very humble beginnings in North Memphis, my quest to become a dentist was never easy, but I made it. Dentistry has not only allowed me to achieve my dreams, but it has also given me a chance to be a blessing to my family and community! This could not have been possible without mentors along the way. I've been introduced to a world I could have never imagined! I'm excited to get to share my experiences and "secrets" with you!

The DDS Program will be held on the campus of The University of Tennessee Health Sciences Center (UTHSC) on a **monthly** basis and offers benefits to all participants, including:

- pertinent information to assist in your pursuit of becoming healthcare professionals
- networking opportunities with college representatives and like-minded students
- a catered lunch
- fun, interactive breakout sessions
- a chance to win cool prizes
- a chance to form mentorships with healthcare professionals
- social events to build friendship bonds

Interested applicants should demonstrate a sincere commitment to pursuing a career in the health sciences. Applicants should also be between the ages of 14-18 at the time of the application submission and represent individuals who are historically under-represented in the health care professions (ethnic minorities, female, live in rural areas, economically-disadvantaged, and/or students of ANY racial background who are the first in their families to pursue higher education).

There is no GPA requirement; however, a copy of your report card OR official transcript are also required. Upon acceptance, additional information will be mailed to selected participants. **There is NO FEE to participate.**

All application materials should be mailed and postmarked by **October 20, 2017**. Materials should be mailed to:

DDS Program
4730 Riverdale Road, Suite #3
Memphis, TN 38141

Finalized details will be e-mailed as well as most correspondence. If you have questions, please send them to: beadoctorsomeday@gmail.com.

I look forward to seeing you!!!!

Sincerely,

Dr. Christina Rosenthal

How did you hear about the Program?
____

DDS Program Application

Applications can be handwritten or typewritten.

Personal Information:
Last Name: ________________________ First Name: ________________________ MI: ____
Address: ____
City: ______________________________________ State: _______ Zip: ________________
Home Phone: (_____) ___________________ Cell Phone: (_____) ____________________
Email Address: ____
Date of Birth: ________________ Age: ______________ Gender: Male Female
School:____
Cumulative GPA:____________________
Highest ACT Score (if taken):__________

Grade Level for the 2017-2018 School Year: (H.S.=high school)
O 8th grade O H.S. freshman O H.S. sophomore O H.S. junior
O H.S. senior O college freshman

Ethnicity:
O Caucasian O African American O Native American O Asian/Pacific Islander
O Hispanic O Other ____

Please bubble the following if applicable:
O I will be the first in my family to pursue higher education.

Economic Data:
Are you (or your parent/guardian) receiving any government assistance (SSI, TANF, Medicaid, Food Stamps or Unemployment)? O yes O no

Do you receive free/reduced lunch? O yes O no

How many people are in your household? _______

Which professional career interests you?
O medicine O dentistry O pharmacy O optometry O veterinary medicine
O research O other ____

Shirt Size: O Small O Medium O Large O XL O 2XL O 3XL O __XL
*Each participant will be given a T-shirt at no additional cost. Students are **required** to wear the shirts the entire day.*

Applicant's Name:_________________________
Date of Birth:_____________________________
School:__________________________________

D.D.S. Determined to be a Doctor Someday

DDS Program Application

Awards/Community and School Involvement
List your awards, extracurricular activities, or organizations (both school and/or community) below along with any positions held (if applicable). You may attach an additional page if necessary.

Award/Activity/Organization *Position Held (if applicable)* *Date(s)*

____
____
____
____
____
____
____
____
____
____

Parental Information:
Mother/Guardian's Name: ____
Address: ____
City: _______________________________ State: _______ Zip: _________________
Home Phone: (_____) ____________________ Cell Phone: (_____) _____________________
Email Address: ____

Father/Guardian's Name: ____
Address: ____
City: _______________________________ State: _______ Zip: _________________
Home Phone: (_____) ____________________ Cell Phone: (_____) _____________________
Email Address: ____

In the event of illness, injury or emergency, the parent(s)/guardian(s) will be notified as soon as possible. Please provide two emergency contacts, other than a parent/guardian below.

____
Name Relationship to Participant Phone

____
Name Relationship to Participant Phone

Student Signature:_______________________________________ Date:_________________________

Parent/Guardian Signature:_________________________________ Date:_________________________

Applicant's Name:__________________________
Date of Birth:______________________________
School:____________________________________

D.D.S.
Determined to be a Doctor Someday

DDS Program Application

Essay

Why I'm Compelled to Become a Doctor

In 250 words or less, describe why you want to pursue a career in the healthcare profession. Essays can be handwritten below or type-written.

Code of Conduct & Rules and Regulations

1. Each student should:
    a. Follow the schedule for academic enrichment activities, meetings, and other planned workshops.
    b. Be on time for all activities.

2. Each student should actively participate, displaying a positive attitude and avoid projecting a negative image or making disparaging remarks.

3. Each student must exemplify acceptable behavior:
    a. Profanity is prohibited.
    b. Inappropriate phone use is prohibited (phones should be kept in vibrate mode).
    c. Smoking is prohibited except in designated areas.
    d. Weapons are prohibited.
    e. Using illegal substances is prohibited.

4. Students are to take 100% responsibility for their behavior and actions.

5. Students must dress appropriately; Men - no hats, no sleeveless shirts, no muscle shirts: Ladies – no sport hats, no midriffs, no short skirts/shorts.

6. No physical violence or threats of physical violence will be allowed.

7. Students are to be respectful and courteous to others, setting an example by adhering to the rules and attempting to perform to their fullest potential.

8. If a student misses more than one Program session, dismissal may occur.

Termination from the program may occur, at the discretion of the Program Coordinator, if any of the prohibited actions set forth are not to.

______________________________ ______________
Signature of Participant Date

______________________________ ______________
Signature of Parent/Guardian Date

NON-LIABILITY FORM

I, ____________________________________, the undersigned, acknowledge my understanding that I may work in, observe in, or be in research or clinical settings, as a participant in the programs at The University of Tennessee Health Science Center. It is my understanding that I will be given information, which includes safety rules and universal precautions for potentially infectious and hazardous settings. I further understand that all necessary efforts will be made to keep work areas safe.

I understand the University of Tennessee has no health or medical insurance to cover my participation in the program and that I should consider obtaining such insurance on an individual basis. Accordingly, I hereby release The University of Tennessee Health Science Center, The 516 Foundation, and The DDS Program/Symposium and its employees, faculty, staff, agents, representatives and assigns, from any and all claims, liabilities, costs, and expenses arising from personal injuries, accidents or property theft, loss, or damage during my participation, or use of equipment related to the summer programs.

I RELEASE, WAIVE, AND DISCHARGE The University of Tennessee Health Science Center, The 516 Foundation, and The DDS Program/Symposium from any and all liability, claims, demands, actions and causes whatsoever, whether or not such liability is based on negligence arising out of or related to any loss, damage or injury that may be sustained by me.

I further AGREE TO HOLD HARMLESS and RELEASE The University of Tennessee Health Science Center, The 516 Foundation, and The DDS Program/Symposium, or internship site from any loss, liability, damage or cost, including court costs and attorney's fees, that may incur due to my participation in summer programs, whether caused by negligence or otherwise.

____

Printed Name of Student

____

Signature of Student Date

____

*Signature of Parent/Guardian Date

* IF PARTICIPANT IS UNDER 18 YRS. OF AGE

MEDIA RELEASE FORM

Dear Parent or Guardian:
Throughout the session, the media may visit our program to cover special events. The University of Tennessee Health Science Center (UTHSC), The 516 Foundation (516) and The DDS Program/Symposium affiliates (DDS), may also wish to use your child's photograph, voice or student work for promotional and educational reasons, such as in publications, posters, brochures and newsletters, on the program's web site, radio station, community fairs or other special events.

Before your child's photograph or voice can be used by the media or by UTHSC, 516, or DDS you must give your permission.

Please sign and return the bottom part of this page stating whether UTHSC, 516, and DDS have permission to use your child's photograph, student work or voice for promotional and educational purposes. Thank you for your cooperation.

1) O **I give my permission** that my child may be filmed/photographed/interviewed by the media during the events and for UTHSC, 516, and DDS to use my child's photograph/work/voice for promotional and educational purposes.

   ____
   Parent/ Guardian Signature (if participant under age of 18) Date

   ____
   Printed Name of Student

2) O **I do not give my permission for** my child may be filmed/photographed/interviewed by the media during the summer session and for UTHSC, 516, and DDS to use my child's photograph/work/voice for promotional and educational purposes.

   ____
   Parent/ Guardian Signature (if participant under age of 18) Date

   ____
   Printed Name of Student

MEDICAL HISTORY FORM

Unfortunately, medical emergencies can occur. In order to render the best emergency care should the need arise, please complete the following questions. The form should be completed and signed by a parent/guardian if the child is under 18 years of age. PLEASE NOTE: The information will not be shared with ANYONE other than the program director and emergency personnel if they are needed.

Participant's Name:____

Date of Birth:____

Weight:________________________ Height:_______________________

Emergency Contact 1:__________________________________ Phone:__________________

Emergency Contact 2:__________________________________ Phone:__________________

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________

Are you on a special diet? ◯ Yes ◯ No ____________

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ____________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________

Comments: ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________ DATE ____________