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www.determinedtobedoctorsomeday.org

August 25, 2018

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 Memphis 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 e-mailed as a pdf file only (no photos) by **October 19, 2018** to beadoctorsomeday@gmail.com.

TIP: You can use an app called Turboscan on your phone to scan, create and send pdf files.

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 2018-2019 School Year: (H.S.=high school)

8th grade H.S. freshman H.S. sophomore H.S. junior
 H.S. senior college freshman

Ethnicity:

Caucasian African American Native American Asian/Pacific Islander
 Hispanic Other _____

Please bubble the following if applicable:

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)? yes no

Do you receive free/reduced lunch? yes no

How many people are in your household? _____

Which professional career interests you?

medicine dentistry pharmacy optometry veterinary medicine
 research other _____

Shirt Size: Small Medium Large XL 2XL 3XL __XL

*Each participant will be given a T-shirt at no additional cost. Students are **required** to wear the shirts the entire day.*



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