MU-AHEC Summer Community Program – 2017

Participation Confirmation Form

Please return this form via email, mail or fax to:
Jessica Schuster
MU-AHEC Office, MU School of Medicine, DC345.00,
Columbia, MO 65212
Fax: 573-882-5666   Email: schusterjm@health.missouri.edu

Institution: ____________________________________________________________

Number of Students we will sponsor: _________

Length of Program *(Please indicate which length of time you prefer):*

_____ 4 weeks, scholarship payment of $1,030.93 per student
_____ 6 weeks, scholarship payment of $1,546.39 per student
_____ 8 weeks, scholarship payment of $2,061.86 per student

☐ Yes, we will pay the scholarship per the amounts above.

☐ We are unable to participate at this time.

Name *(please print)*: ___________________________________ Title: __________________________

Signature: ___________________________ Date: __________________________

Phone: ___________________________ Email: __________________________

*June 1 is the anticipated date that the student will be available to begin the program, but dates are flexible, depending upon physicians’ and students’ schedules.

HOUSING

☐ Yes, we will be able to provide housing for the student (if needed)

☐ No, we will not be able to provide housing for the student

Type of Housing Available:

_____ Private Hospital Room
_____ Apartment (single)
_____ Apartment (shared, single sex)
_____ Apartment (shared, co-ed)
_____ House (shared, single sex)
_____ House (shared, co-ed)

Student Housing Address (required):

________________________________________________________________________
Please complete the following contact sheet.

*Once a student’s application has been received we will contact the following individuals to set up the rotation and all specifics related to the rotation.*

1. **Administrative Contact:** Individual to contact regarding participation and payment of student stipend.

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<th>First Name</th>
<th>Last Name</th>
<th>Title</th>
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Phone: ___________________  Email: _______________________

2. **Credentialing Contact:** Individual to contact to verify and submit student credentialing information.

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Phone: ___________________  Email: _______________________

3. **Housing Contact:** Individual to contact to schedule student housing.

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Phone: ___________________  Email: _______________________

4. **Preceptor Scheduling Contact:** Individual to contact to schedule the rotation with the physician preceptor(s).

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Phone: ___________________  Email: _______________________

5. Please indicate who the student should contact prior to their arrival to schedule mandatory orientations and/or training, and who to contact in regards to accessing the provided housing if applicable (If not listed above please provide contact information).

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