

Research Presentations (title; name of meeting; date; poster or platform):

1. _____
2. _____
3. _____

Research Awards / Honors:

Letters of Recommendation:

1. **Research Mentor(s) (Name, Location, Phone):** _____

2. **Science Course Teacher (Name, Location, Phone):** _____

3. **Other (Name, Location, Phone):** _____

Research Interest(s) / Discipline for Doctoral Research:

1. _____
2. _____

Clinical Medicine Field(s) of Interest, currently:

Healthcare Experiences (type; dates):

I certify that all information submitted is correct and complete to the best of my knowledge.

Signature _____ Date _____

*To email this form, simply type your name and today's date.

**M.D./Ph.D Physician Scientist Program
Office of Graduate Studies – 5015 Wescoe
University of Kansas Medical Center
3901 Rainbow Boulevard
Kansas City, Kansas 66160-7700
(913-588-5241)**