



MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM

To apply: Complete the application form in full. Be sure to answer the two essay questions below on a separate sheet. It must be typed. Have your teacher, counselor, or the appropriate representative complete the portion of the Teacher/School Counselor Recommendation form. Your institution representative must verify your rank and GPA in the counselor portion of the application. Submit your application and recommendation to your school counseling office. Make sure that supplemental materials are submitted with your application. Please do not submit additional documentation (i.e., extra recommendation letters, resumes, etc.)

APPLICANT INFORMATION: I have participated in the program before: True False

Name _____
Last First Middle Preferred Name

Address _____
Street City Zip Code

Current School/Institution Name _____

(Post Secondary Students) Current major _____ GPA _____

Anticipated Graduation Year _____

Biggest area of support needed _____

Date of Birth _____ Ethnicity _____ T-shirt size _____

Email: _____ Student Cell No. _____

EMERGENCY CONTACT INFORMATION:

Contact 1: _____ Relation to student: _____

Cell No. _____ Email address _____

Contact 2: _____ Relation to student: _____

Cell No. _____ Email address _____

Home Telephone _____

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.



MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM

SHORT ANSWERS:

Please type in your answers to both prompts and attach to this form when you submit it. Make sure you write your name on the sheet of your short answers and label each response. Answer each prompt separately using at least 150 words, but no more than 300 words for middle school, high school, and post-secondary participants.

1) Why do you want to participate in the My Pace Program? (What do you hope to do, learn or gain from this experience?)

2) What made you become interested in a career in the healthcare industry?

3) How do you see the My Pace Program helping you to accomplish your career goals?

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.



MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM

MY PACE ROUTE INTRODUCTION

Please rank each route on a 1-5 scale with 1 (one) being your top interest and 5 being your least interest. Then, for each career or job listed under that route, mark an “X” to indicate which career or job sounds interesting or you would like to learn more about. Please note all careers or jobs are not listed in this list; this list is your introduction to these unique routes in the healthcare industry.

_____ **Route 1: Diagnostic Focus**

- | | |
|---|---|
| <input type="checkbox"/> EKG technician | <input type="checkbox"/> Ultrasound technician |
| <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Dental laboratory technician |
| <input type="checkbox"/> Radiology technician | |

_____ **Route 2: Therapeutic Services**

- | | |
|--|--|
| <input type="checkbox"/> Certified Nurse Assistant (CNA) | <input type="checkbox"/> Paramedic |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Respiratory therapist |
| <input type="checkbox"/> Occupational therapist | |

_____ **Route 3: Health Informatics**

- | | |
|---|--|
| <input type="checkbox"/> Medical administrative assistant | <input type="checkbox"/> Medical transcriptionist |
| <input type="checkbox"/> Health information technician | <input type="checkbox"/> Health care administrator |
| <input type="checkbox"/> Nurse manager | |

_____ **Route 4: Biotechnology Research and Development**

- | | |
|--|---|
| <input type="checkbox"/> Toxicologist | <input type="checkbox"/> Cytotechnologist |
| <input type="checkbox"/> Biomedical engineer | <input type="checkbox"/> Epidemiologist |
| <input type="checkbox"/> Forensic science technician | |

_____ **Route 5: Support Services**

- | | |
|--|--|
| <input type="checkbox"/> Dietary technician | <input type="checkbox"/> Hospital maintenance engineer |
| <input type="checkbox"/> Biomedical equipment technician | <input type="checkbox"/> Central services technician |
| <input type="checkbox"/> Medical librarian | |

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.



**MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM
PROGRAM PROFESSIONAL RECOMMENDATION:**

Directions: Have the applicant complete the Applicant portion of this Teacher/Advisor/Professor/School Counselor Recommendation form. Any professional reference (former professor, teacher, counselor, supervisor, mentor, etc.) would be ideal to complete this recommendation form. Return your recommendation form along with the additional sheets to a *My Pace* representative.

APPLICANT INFORMATION:

Name _____

Last

First

Middle Initial

School _____ School Tel. _____

School Counselor/Advisor _____ Tel. _____

PLEASE SUBMIT A BRIEF (500 WORDS OR LESS) RECOMMENDATION FOR THE APPLICANT'S PARTICIPATION IN THE MY PACE PROGRAM.

OVERALL RECOMMENDATION: (mark one)

- I recommend the candidate without reservation
- I recommend the candidate with reservation (please explain on another sheet)
- I believe the candidate is unsuited for the program at this time.

NAME: (Please Print) _____ Title: _____

Signature: _____ Date: _____

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.



MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM
Photo and Media Release Form for the My Pace Program

Place an x beside the paragraph granting or denying GRAAHI's permission to use your student's photo.

_____ I affirm The Grand Rapids African American Health Institute (GRAAHI) **has** my permission to use my or my student's photograph internally and publicly to promote the My Pace Program. I agree that GRAAHI may use photographs with or without my or my student's name. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

_____ I deny The Grand Rapids African American Health Institute (GRAAHI) my permission to use my or my student's photograph internally or publicly to promote the My Pace Program. This applies to print publications, online publications, presentations, websites, and social media.

Student's Name: _____

Student's Signature (if above 18+): _____ Date

Parent/Guardian's Name (printed): _____

Parent/Guardian Signature

Date

My Pace Program through Grand Rapids African American Health Institute

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.



MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM
Permission for Attendance; Waiver of Claims; and Consent for Emergency Medical Care

_____ has my permission to attend the My Pace’s college empowerment program held at their local school and beyond. This permission includes travel to and from the school campus, including travel by bus, and participation in all of the programs and activities scheduled as part of the My Pace, including travel to medical facilities.

Acknowledgment, Release, and Assumption of Risk

I acknowledge that enrollment in the My Pace program through the African American Health Institute (GRAAHI) includes the requirement for travel to and from the medical facilities located in downtown Grand Rapids and the several college/university campuses, and participation in the full spectrum of college life at multiple institutions, including classroom attendance; traveling throughout campus; residing in the dormitories; dining at campus food service facilities; engaging in organized or spontaneous recreational events; and having full access to the facilities ordinarily used by students on the host campuses. I agree that, on behalf of myself and the enrollee identified above, I assume all risks ordinarily attendant to participation in this program, and I hereby waive and release the My Pace program and its officers, employees, and volunteers from and against any claim for liability arising out of any personal injury, including death, or any property damage, including theft, which occurs or relates to the enrollee’s participation in the My Pace program. I also agree to indemnify and hold harmless the My Pace program from and against any claim arising out of the enrollee’s attendance, conduct, and activities within the program.

Parent/Guardian Signature

Date

Parent/ Guardian Consent for Medical Treatment

I, _____, legal guardian of _____, authorize the
(Parent/Guardian name) *(name of student)*

My Path staff to grant consent for medical treatment for the enrollee in the case of an emergency during My Path or arising out of attendance at My Path. I assume all financial responsibility for medical costs arising from emergency medical care over and above costs covered by the personal insurance benefits provided by me for the enrollee named above.

Parent/Guardian signature

Date

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.



MY PACE – POSTSECONDARY AND CAREER ACCESS PROGRAM

Emergency and Hospitalization Insurance

Please list enrollee's allergies or medical problems, if any _____

Routine medications taken by enrollee _____

Special diet requirements _____

Last tetanus shot (date) _____

Insurance Company _____ Policy # _____

Name of Primary Person Insured _____ Pre-admission telephone # _____

Name of Primary Physician _____ Primary Physician telephone # _____

REMEMBER ALL FORMS AND RESPONSES MUST BE COMPLETE AND SUBMITTED TOGETHER.