## 2010 Application Checklist

### Teaching & Learning Program

<table>
<thead>
<tr>
<th>Application Fee</th>
<th>Resume</th>
<th>Transcripts</th>
<th>Recommendations</th>
<th>Essay</th>
<th>Copy of health care license or permission of program coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching &amp; Learning Certificate of Advanced Study</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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### Legend:
- ✔️ = Required
- Not Req. = Not Required
Please read the following instructions carefully. Your application for admission will be evaluated after the Office of Student Affairs has received ALL required materials. It is your responsibility to be certain that all necessary materials have been received by the Office of Student Affairs prior to the deadline.

1. APPLICATION FOR ADMISSION: Applicants are asked to collect and submit all application materials, including sealed official transcripts and sealed recommendation letters in one envelope. Please make sure your full legal name is included on all materials being submitted.

Please mail your application to the following address:

MGH Institute of Health Professions
Office of Student Affairs
PO Box 6357
Boston, MA 02114

Keep in mind that Federal Express and UPS mail cannot be accepted at a P.O. Box address. If you must send materials by express service, please send it to our street address, as listed below:

MGH Institute of Health Professions
Office of Student Affairs
36 1st Ave.
Charlestown Navy Yard
Boston, MA 02129

* We will acknowledge the receipt of all applications by email.

2. $65 NON-REFUNDABLE APPLICATION FEE: Please make checks payable to the MGH Institute of Health Professions.

3. MINIMUM DEGREE REQUIREMENT: A Bachelor’s degree from an accredited college or university.

4. APPLICATION DEADLINE:

   - Fall Entry - Rolling Admission
   - Spring Entry - Rolling Admission
   - Summer Entry - Rolling Admission

5. RESUME: Please submit a current resume or CV.
6. **OFFICIAL TRANSCRIPTS:** Applicants must submit official transcripts from all colleges and universities attended, even if a degree was not received from that institution. Include undergraduate and graduate course work. Sealed official transcripts should be mailed with the application packet. For courses in progress, transcripts should be forwarded upon completion.

*Applicants who did not receive their undergraduate degree in the United States must have their degree transcript evaluated by a credentialing agency. When requesting a transcript evaluation, please request a “course-by-course” evaluation with grades. Preferred credentialing agencies are listed on our website.*

7. **RECOMMENDATION LETTERS:**

Applicants are required to submit three letters of recommendation. Recommendation letters should come from individuals who are able to address your academic ability and potential for graduate professional study. At least one letter should come from an academic reference. **Please provide recommenders with a self-addressed, stamped envelope to expedite its return. No more than three recommendation letters will be reviewed as part of your application.**

8. **PERSONAL ESSAY:** Applicants are required to answer the essay question listed below. Answers should be typed, double-spaced, and no more than three pages in total. Margins should be no more than one inch, and type size should be no smaller than 10-point, with 12-point type preferred. Please make sure your full legal name and the last four digits of your social security number are included on each page:

- Share/discuss your vision for yourself in the role of health care educator, including your future goals and plans. Your comments may reflect your personal experiences and beliefs about health care that have influenced your interest in the area of education. Specify the types of health care roles and responsibilities that have contributed to your decision to pursue study in health care education. You may choose to share stories of influential educators to illustrate your points.

9. **TOEFL (Test of English as a Foreign Language):**

Official results of the TOEFL, taken within the last two years, are required of all applicants whose native language is not English. The minimum score requirement is 213 (computer-based test), 79-80 (Internet-based test) or 550 (paper-based test). Scores must be sent directly to the Institute by the testing service. This requirement is waived only if the applicant has received or expects to receive prior to enrollment, an undergraduate or graduate degree from a college or university in any of the following countries: The United States of America, New Zealand, and Canadian institutions where the language of instruction is English. A waiver may also be granted if a credentialing agency can show that the medium of instruction at the undergraduate or graduate institution where the degree was awarded was English. **The MGH Institute of Health Professions school code is R3513.**

10. **ADDITIONAL PROGRAM REQUIREMENTS:**

- Copy of health care license or permission of program coordinator.

11. **RESIDENCY REQUIREMENT:** Because a significant portion of the curriculum is taught online, international students seeking an F-1 visa through the MGH Institute of Health Professions are not eligible to apply for the program. International students not seeking an F-1 visa through the MGH Institute of Health Professions are eligible to apply and should contact the Manager of Admissions in the Office of Student Affairs early in the application process.

**PROGRAM CONTACT INFORMATION:**

Email: pvivek@mghihp.edu
Phone: (617) 724-6362
The Institute’s preference is for all students to apply online through our website: www.mghihp.edu
Applicants who choose to fill out a paper application may experience a delay in processing.

I. PERSONAL INFORMATION

Have you ever attended the MGH Institute of Health Professions?  ____YES  ____ NO

Are you currently an employee of the Partners Healthcare System?  ____ YES  ____ NO
If so, where are you employed? ____________________________________________________

LAST __________________________ FIRST _________________________   MIDDLE _______________

Please list other names which may have previously appeared on academic records: ____________________________

Social Security # _________________________ Date of Birth _____ / _____ / _____
(used for identification purposes only)  Month / Day / Year  □ Male  □ Female

Current Address (valid until ______________): ______________________________________________________

____________________________________________________________________________________________________________________

City      State      Zip
___________________________________________

Current Phone: (       ) _____ - ________

Country

Permanent Address: __________________________________________________________________________

Number     Street
___________________________________________________________________________       _______________________________________

City   State   Zip    Country

Permanent Phone: (       ) ______ - ___________  Email Address: _________________________________

II. CITIZENSHIP AND VISA INFORMATION

Are you a United States citizen?  □ Yes  □ No  If not, what country are you a citizen of? ____________________________

Do you hold Permanent Resident status?  □ Yes  □ No  Alien Registration number: ________________________
(provide a copy of your card)

What is your expected visa status during your studies in the United States?  □ F-1  □ Other ____________________________
(type)

Are you a U.S. Veteran?  □ Yes  □ No  If yes, are you receiving Veterans benefits?  □ Yes  □ No

For Office Use Only:  Date application received: ______________  Received by: ______________

Application fee received: ______  Credit Card: ______  Check: ______  Check Number: ______

Portfolio fee received: Credit Card: Check: Check Number: ______
III. PROGRAM OF STUDY

Program you are applying to:

☐ Teaching & Learning Certificate of Advanced Study

Start Term:  ☐ Fall

Year:  20___ (fill in year)

IV. EDUCATION

List all schools attended beyond high school, including schools at which you are currently enrolled. Please list schools chronologically (most recent first). GPA is required only from institutions where a degree was received.

<table>
<thead>
<tr>
<th>Name of College/University</th>
<th>Dates Attended</th>
<th>Degree</th>
<th>Major</th>
<th>GPA</th>
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</tbody>
</table>

Do you believe that your academic record accurately reflects your ability?  ☐ Yes  ☐ No

If not, please explain. Attach additional sheets if necessary.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

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____________________________________________________________________________________________________

V. STANDARDIZED TESTS

Please refer to the application instructions for more detailed information regarding required standardized tests for your program of study.

NOTE: Official reports of TOEFL scores should be sent directly to the MGH Institute of Health Professions from the testing service (ETS).

Test of English as a Foreign Language scores (TOEFL) taken within the past 2 years:

Applicants whose native language is not English and/or who did not receive a degree from a college or university whose language of instruction is English must take the TOEFL.

Have taken:  _____ / _____ / ______  Test results: _________________

Test results: ____________________

Plan to take:  _____ / _____ / ______  (Test must be taken prior to the program’s application deadline)
VI. WORK EXPERIENCE (Please include CV or resume)

Include honors, awards and publications or any professional organizations and/or community activities you have been involved in on your resume, if applicable.

VII. RECOMMENDATIONS

Please provide contact information in the space below for those who will be completing a recommendation form on your behalf:

1. Name: ____________________________________________
   Last                          First
   Organization: ___________________________ Title: ___________________________
   Address: ____________________________________________________________________
   Street                          City       State       Zip
   Email Address: ___________________________ Relationship to applicant: ________________

2. Name: ____________________________________________
   Last                          First
   Organization: ___________________________ Title: ___________________________
   Address: ____________________________________________________________________
   Street                          City       State       Zip
   Email Address: ___________________________ Relationship to applicant: ________________

3. Name: ____________________________________________
   Last                          First
   Organization: ___________________________ Title: ___________________________
   Address: ____________________________________________________________________
   Street                          City       State       Zip
   Email Address: ___________________________ Relationship to applicant: ________________
VIII. APPLICANT AFFIDAVIT

I hereby certify that the information given on this application is complete and correct to the best of my knowledge, and that I have attended no other institution other than those I’ve listed. I understand that all documents sent to the MGH Institute of Health Professions become the property of the MGH Institute of Health Professions and will not be returned to me or duplicated for any reason. I further acknowledge that the application fee only partially covers the cost of processing my application and that the fee is non-refundable. I understand that if I am accepted to the MGH Institute of Health Professions, my admission is contingent upon verification of all official records from the institutions I’ve attended, as well as satisfactory completion of all outstanding admission requirements. I understand that any misrepresentation or omission with regards to this application my result in refusal of admission or cancellation of registration. I understand that the MGH Institute of Health Professions reserves the right to rescind any and all acceptances to the institution.

Signature of applicant ___________________________  Date ___________________________

It is the policy of the MGH Institute of Health Professions not to discriminate on the basis of race, color, creed, gender, gender identity or expression, sexual orientation, age, disability, veteran status, marital status, or national origin. The institute respects and values the diverse backgrounds of all people, and welcomes all students to fully participate in all the rights, privileges, programs, and activities generally accorded or made available to the Institute community. This policy incorporates, by reference, the requirements of Title VII of the Civil Rights Act, Title IX of the 1972 Educational Amendments, and all relevant federal, state, and local laws, statutes, and regulations.

In compliance with the Jeanne Clery Disclosure Act of 1998, MGH Police and Security provides information annually about crime statistics within our community. A copy of this information is available at the office of MGH Police and Security or at http://ope.ed.gov/security.

OPTIONAL:

The MGH Institute of Health Professions provides equality of opportunity to all students. Ethnic and profile information is only used to complete reports required by the government and/or accrediting agencies. This information will not influence the Institute’s decision regarding admission.

Please indicate your primary ethnic background:

☐ Hispanic / Latino  ☐ Non-Hispanic / Latino

Please indicate your primary racial background:

☐ Black or African-American  ☐ American / Alaskan Native
☐ Hawaiian / Pacific Islander  ☐ Asian
☐ White  ☐ Other _____________________________
INSTRUCTIONS FOR APPLICANT: Please fill out top section and forward to recommenders. Make sure to provide each recommender with a self-addressed, stamped envelope to expedite its return.

Name: _____________________________ Social Security Number (last 4 digits): __________________

Program of study: Teaching and Learning Certificate of Advanced Study

The Family Educational Rights and Privacy Act of 1974 and its amendments guarantee students access to educational records concerning them. Students are also permitted to waive their right of access to recommendations. The following signed statement indicates the wish of the applicant regarding this recommendation. Failure to respond will be considered a waiver of the right of access to this recommendation. This waiver is not required for admission.

___ I waive my right to inspect this recommendation
___ I do not waive my right to inspect this recommendation

Signature: _______________________________________________

INSTRUCTIONS FOR RECOMMENDER:

Please complete sections A and B and return the completed form in a sealed envelope with your signature across the seal to preserve the confidentiality of this document.

A. Please provide a letter of recommendation that addresses the potential of the applicant to be a post-baccalaureate or graduate student, including any additional comments concerning maturity, critical thinking skills, ability to adapt to change, or any other factors that you think may be pertinent to the student’s performance in a professional curriculum. Additionally, it is important for us to assess the potential of each student to succeed in a clinical environment. If you feel qualified to make this assessment, please include your comments in this evaluation. Please feel free to attach additional pages as necessary.

RECOMMENDER NAME: ___________________________________________________________________

TITLE: __________________________________________ DATE: _________________________________

INSTITUTION/COMPANY TITLE: ____________________________________________________________

ADDRESS: ________________________________________ CITY: _____________________ STATE: ______________

PHONE: __________________________________________ EMAIL ADDRESS: _______________________________

SIGNATURE: _________________________________________________________________________________________

RELATIONSHIP TO APPLICANT: ____ ACADEMIC     ____ PROFESSIONAL      ____ OTHER

How long have you known the applicant? _________________________________________________
B. Please rank the applicant with respect to each category below:

<table>
<thead>
<tr>
<th>Category</th>
<th>EXCELLENT</th>
<th>GOOD</th>
<th>AVERAGE</th>
<th>BELOW AVERAGE</th>
<th>NO BASIS TO JUDGE</th>
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<tbody>
<tr>
<td>Overall intellectual ability</td>
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<td>Written expression</td>
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<td>Oral expression</td>
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<td>Flexibility</td>
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<td>Ability to organize and apply information</td>
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<td>Problem solving skills</td>
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<td>Maturity and emotional stability</td>
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<td>Initiative and perseverance</td>
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<td>Curiosity</td>
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<td>Potential for (or actual) clinical competence</td>
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<td>Ability to handle stressful situations</td>
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<td>Ability to interact well with others</td>
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<td>Ability to accept constructive feedback</td>
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<td>Ability to work independently</td>
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<td>Capacity for Graduate study</td>
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<td><strong>Overall Impression:</strong></td>
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<td>_____ Strongly recommend    _____ Recommend   _____ Recommend with reservations _____ Do not recommend</td>
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</table>

Thank you for taking the time to assist us through the application and evaluation process. Your input is valued and greatly appreciated.