A.T. STILL UNIVERSITY
KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE | ATSU

&

MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY

Name _____ _____
Last First Middle Social Security Number

College Address _____
Street Address City State Zip Code

College Telephone (____) ____-_____ **Email Address** _____

Permanent Address _____
Street Address City State Zip Code

Telephone (____) ____-_____ **Birthdate** _____ **Place of Birth** _____

U.S. Citizen Yes ___ No ___ **Permanent U.S. Resident** Yes ___ No ___ **Gender** Male___ Female___

Racial/Ethnic Self Description _____

Father/Guardian _____ **Living** Yes___ No___

Permanent Address _____
Street Address City State Zip Code

Telephone (____) ____-_____ **Education/College(s)** _____

Degree(s) _____ **Occupation** _____

Mother/Guardian _____ **Living** Yes___ No___

Permanent Address _____
Street Address City State Zip Code

Telephone (____) ____-_____ **Education/College(s)** _____

Degree(s) _____ **Occupation** _____

University Grade Point Average _____ **ACT/SAT Score** _____

Academic Advisor _____ **Telephone** (____) ____-_____

University Extracurricular Activities

Medically Related Activities

Employment

Why are you applying to the Still Scholars Program?

What are your future goals as an osteopathic physician?

Applicant Signature **Date**

A.T. STILL UNIVERSITY
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MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY

Evaluation Information

To be completed by student and submitted with application

Evaluation I

Pre-Health Advisor and/or Science Faculty Member

Name _____

Title _____

Address _____
Street

_____
City State Zip Code

Telephone (_____) _____-_____

Evaluation II

Faculty Member, Staff member, or Employer

Name _____

Title _____

Address _____
Street

_____
City State Zip Code

Telephone (_____) _____-_____

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MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY

Evaluation I

Pre-Health Advisor and/or Science Faculty Member

Please attach letter on official letterhead. This form can be used as a reference.

I. APPLICANT INFORMATION (to be completed by applicant)

Legal Name of Applicant _____
Last First Middle

Social Security Number _____

Permanent Address _____

_____

I voluntarily waive and relinquish my right of access to this evaluation.

_____ _____
Applicant's Signature Date

I retain my right of access to this evaluation.

_____
Applicant's Signature Date

II. EVALUATOR INFORMATION (to be completed by evaluator)

Name _____

Rank or Title _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Evaluator Signature _____

III. EVALUATOR COMMENTS (to be completed by evaluator)

State nature, duration, and extent of your association with the applicant _____

_____

Has applicant ever been placed on disciplinary or academic probation? _____ Yes _____ No

Are you familiar with how the applicant reacts in a stressful or crisis situation? _____ Yes _____ No

If yes, explain: _____

_____

_____

What unique strengths and/or potential for contribution to medicine does this applicant possess? _____

_____

_____

Please describe any weaknesses of this applicant. _____

_____

Please give your overall impression of this applicant. _____

_____

_____

Please check how you would rate this applicant on the following characteristics:

CHARACTERISTIC	OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	UNABLE TO JUDGE
Cooperation					
Initiative					
Study Habits					
Intellectual Curiosity					
Intellectual Ability					
Judgment					
Expression					
Maturity					
Personality					
Reliability					
Leadership					
Personal Hygiene					
Emotional Stability					
Ethical Standards					
Self-Understanding					
Attitude Toward Associates					
Ability to Inspire Confidence					

Do you recommend this applicant to the Still Scholars Program? ___Yes ___No ___ Undecided

Why or why not? _____

_____

.

Please mail completed evaluation by _____ **to**:

A.T. STILL UNIVERSITY
KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE | ATSU

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MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY

Evaluation II

Faculty Member, Staff member, or Employer

Please attach letter on official letterhead. This form can be used as a reference.

IV. APPLICANT INFORMATION (to be completed by applicant)

Legal Name of Applicant _____
Last First Middle

Social Security Number _____

Permanent Address _____

_____

I voluntarily waive and relinquish my right of access to this evaluation.

_____ ____
Applicant's Signature Date

I retain my right of access to this evaluation.

_____
Applicant's Signature Date

V. EVALUATOR INFORMATION (to be completed by evaluator)

Name _____

Rank or Title _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Evaluator Signature _____

VI. EVALUATOR COMMENTS (to be completed by evaluator)

State nature, duration, and extent of your association with the applicant _____

_____

Has applicant ever been placed on disciplinary or academic probation? _____ Yes _____ No

Are you familiar with how the applicant reacts in a stressful or crisis situation? _____ Yes _____ No

If yes, explain: _____

_____

_____

What unique strengths and/or potential for contribution to medicine does this applicant possess? _____

_____

_____

Please describe any weaknesses of this applicant. _____

_____

Please give your overall impression of this applicant. _____

_____

_____

Please check how you would rate this applicant on the following characteristics:

CHARACTERISTIC	OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	UNABLE TO JUDGE
Cooperation					
Initiative					
Study Habits					
Intellectual Curiosity					
Intellectual Ability					
Judgment					
Expression					
Maturity					
Personality					
Reliability					
Leadership					
Personal Hygiene					
Emotional Stability					
Ethical Standards					
Self-Understanding					
Attitude Toward Associates					
Ability to Inspire Confidence					

Do you recommend this applicant to the Still Scholars Program? ___Yes ___No ___ Undecided

Why or why not? _____

_____

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Please mail completed evaluation by _____ **to**: