Robert Wood Johnson Foundation | Center for Health Policy at Meharry Medical College

Robert Wood Johnson Foundation Center for Health Policy
Health Policy Scholars Program

2015 – 2016 APPLICATION

APPLICANT INFORMATION

Legal Name _____
First Middle Last Maiden Suffix

Date of Birth ____/____/____ Sex □Male □Female Race/Ethnicity _____

State of Legal Residence _____ Country of Citizenship _____

Visa Type (If applicable) _____

Local Address _____ (___) _____
Street City, State, Zip Code Phone Number

Permanent Address _____ (___) _____
Street City, State, Zip Code Phone Number

Email Address _____

ACADEMIC INFORMATION *(complete A, B, or C)*

A. Current Academic Institution _____ Expected Graduation Date _____
B. Current MMC Program □MD □DDS □PhD □MSPH Expected Graduation Date _____
C. Current Employer _____ Title _____

List all colleges and universities attended in chronological order:

Name of Institution	Begin Date (MM/YYYY)	End Date (MM/YYYY)	Major(s)	Degree

I understand that withholding information requested on this application or giving false information will make me ineligible for admission to Meharry Medical College or subject to dismissal. With this in mind, I certify that the above statements are correct and complete. By submission of this application, I authorize release of my Meharry transcript to the health policy admissions committee.

_____ _____
Signature of Legal Name Date