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