OSBORNE HEAD & NECK institute
Medical Scholars Program

Medical Scholars Program Application

CURRENT GRADE IN SCHOOL
☐ 10th ☐ Other: _____
☐ 11th
☐ 12th

HAVE YOU APPLIED TO THIS PROGRAM IN THE PAST?
☐ Yes (Year: _____)
☐ No

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Male/Female: _____ **Date of Birth:** _____

Street Address: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Parent 1/Guardian Name: _____ **Cell Phone:** _____

Parent 1/Guardian Email: _____

Parent 2/Guardian Name: _____ **Cell Phone:** _____

School Name: _____

School Address: _____

Guidance Counselor: _____ **Telephone:** _____

Guidance Counselor's Email: _____

Physician's Name: _____ **Telephone:** _____

Disclosure: All applicants must answer the following question. Failure to answer honestly will disqualify the applicant from service as a volunteer in the Medical Scholars Program at the Osborne Head and Neck Institute (OHNI).

Have you ever been convicted of a crime? ☐ **Yes** ☐ **No**
If Yes, please describe each conviction in full. Please list all crimes and the date and place where they occurred (Attach a separate sheet if needed).

I, the undersigned parent or legal guardian of the above-named student volunteer, a minor ("Student Volunteer"), on behalf of myself, Student Volunteer and our heirs, assigns and next of kin, hereby agree as follows:

EMERGENCY AUTHORIZATION: I hereby authorize an employee of the Osborne Head and Neck Institute ("OHNI"), the above identified Emergency Contact and/or other officials to act as my agents in the capacity of authorizing medical, surgical or dental examination and/or treatment for the Student Volunteer if I am not available.

DISCLAIMER, ASSUMPTION OF RISK AND WAIVER: I acknowledge that participation in the Medical Scholars Program involves exposure to patients who have illnesses, diseases and injuries. I understand that my child may be exposed to blood and bodily fluids and I willingly and voluntarily accept and assume all such risk.

I willingly and voluntarily agree to comply with the stated and customary terms and conditions for participation and, if Student Volunteer or I observe any unusual significant concern in his/her readiness for participation and/or in the program itself, I will remove Student Volunteer from participation and bring such concern to the attention of the nearest staff member immediately.

I HAVE READ THE ABOVE DISCLAIMER, ASSUMPTION OF RISK AND WAIVER AND THE EMERGENCY AUTHORIZATION, AND THE ACKNOWLEDGEMENT AND FULLY UNDERSTAND THE TERMS OF EACH, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY MY SIGNING THIS FORM AND AGREEING TO THESE TERMS, AND I SIGN THIS FORM AND AGREE TO THESE TERMS FREELY AND VOLUNTARILY AND WITHOUT INDUCEMENT OF ANY KIND. FURTHERMORE, I AGREE TO INFORM OHNI IN A TIMELY MANNER IF ANYTHING ON THIS FORM OR ITS ATTACHMENTS CHANGES.

Parent/Guardian **Date**

Student Volunteer **Date**

In consideration of accepting and permitting the voluntary participation of Student Volunteer in the Medical Scholars Program, I hereby release, discharge and agree to hold harmless to the fullest extent permitted by law, Osborne Head and Neck Institute, its physicians, employees, volunteers, officials and other representatives and any and all owners, lessors, lessees or other persons or entities allowing, permitting or authorizing the use of facilities by OHNI and the agents, employees, officers and directors of said persons or entities from any and all claims, demands, costs, expenses and compensation arising out of or in any way related to any injury or other damage that may result to Student Volunteer or to members of my family or my household. Student Volunteer is otherwise responsible while participating in or present at any OHNI-sponsored event, including any physical or other injury caused by the negligence of any person or entity described above.

I further acknowledge and accept that this Disclaimer, Assumption of Risk and Waiver is intended to be as broad and inclusive as permitted by the laws in the state of California in which Student Volunteer's participation takes place and agree that if any portion of this Disclaimer, Assumption of Risk and Waiver is deemed to be invalid, the remainder will continue in full legal force and effect.

ACKNOWLEDGEMENT AND CONSENT: I, the undersigned parent or legal guardian of the above-named student volunteer, a minor ("Student Volunteer"), on behalf of myself, Student Volunteer and our heirs, assigns and next of kin, hereby agree as follows:

EMERGENCY AUTHORIZATION: I hereby authorize a staff member of the Osborne Head and Neck Institute ("OHNI"), the above identified Emergency Contact to act as my agents in the capacity of authorizing medical, surgical or dental examination and/or treatment for Student Volunteer if I am not available.

Parent/Guardian **Date**

Student Volunteer **Date**

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Medical Scholars Program Application Checklist

☐ **Cover Sheet with Photo**

☐ **Application Form**

☐ **Application Essay**

i. **Applicant Prompt**: Why do you want to participate in the Medical Scholars Program? Why are you interested in a career in medicine?

☐ **Resume/CV**

☐ **School Transcript (with GPA)**

☐ **Guidance Counselor Statement of Academic Good Standing**

Please direct all questions and completed applications to:

Alex Fernandez, MS Program Director
Osborne Head and Neck Institute
8631 W. 3rd Street, Suite 945E
Los Angeles, CA 90048
310-657-0123
alex@ohni.org

SAMPLE COVER SHEET

Jane Smith
Jane@ohni.org

8631 W. 3rd Street, Suite 945E
Los Angeles, CA 90232

Home: (310) 657-0123
Cell: (310) 657-0123

EMERGENCY CONTACTS:
Parent 1 Cell: (310) 657-0123
Parent 2 Cell: (310) 657-0123