



MEDICAL UNIVERSITY OF LUBLIN – APPLICATION FORM

ADMISSION IN THE ACADEMIC YEAR 2020/2021

UNIWERSYTET MEDYCZNY W LUBLINIE – FORMULARZ APLIKACYJNY NA ROK 2020/2021

THE AMERICAN MD PROGRAM IS OFFERED BY THE MEDICAL UNIVERSITY OF LUBLIN IN COOPERATION WITH HOPE MEDICAL INSTITUTE. APPLICATIONS CAN BE SUBMITTED TO THE MEDICAL UNIVERSITY OF LUBLIN OR HOPE MEDICAL INSTITUTE /

PROGRAM AMERYKAŃSKI OFEROWANY JEST PRZEZ UNIWERSYTET MEDYCZNY W LUBLINIE WE WSPÓŁPRACY Z HOPE MEDICAL INSTITUTE. APLIKACJE MOGĄ BYĆ SKŁADANE W SIEDZIBIE UCZELNI LUB HMI:

www.umlub.pl/en

Medical University of Lublin

Faculty of Medicine

Ul. Witolda Chodźki 19, 3rd Floor

20-093 Lublin, POLAND

Phone: +48 81 448 63 10

Fax: +48 81 448 63 11

admissions@umlub.pl

www.hopemedicalinstitute.org

Hope Medical Institute

11835 Rock Landing Drive

Newport News, VA 23606

USA

Phone: 757-873-3333

Fax: 757-873-6661

e-mail: admissions@hmi-edu.org

I AM NOT A POLISH CITIZEN AND I WISH TO APPLY TO / NIE JESTEM POLSKIM OBYWATELEM I APLIKUJĘ NA STUDIA NA:

MD American Program

MD Advanced American Program

BEGINNING IN / ROZPOCZYNAJĄCE SIĘ W:

FALL 2020

PERSONAL DATA /DANE OSOBOWE:

LAST NAME / NAZWISKO:	****last_name****
NAMES / IMIONA:	*****NAMES ****
GENDER /PLEC:	***GENDER***
DATE OF BIRTH [DD-MM-YYYY] / DATA URODZENIA:	*****DATE****
PLACE OF BIRTH /MIEJSCE URODZENIA::	****PLACE OF BIRTH****
COUNTRY OF BIRTH /KRAJ URODZENIA:	*****COUNTRY OF BIRTH*****
CITIZENSHIP /OBYWATELSTWO:	****CITIZENSHIP***
TYPE OF IDENTITY DOCUMENT / RODZAJ DOKUMENTU TOŻSAMOŚCI:	*****TYPE OF IDENTITY*****
NUMBER OF IDENTITY DOCUMENT /NUMER DOKUMENTU TOŻSAMOŚCI:	*****NUMBER*****
ISSUING AUTHORITY /ORGAN WYDAJĄCY:	*****ISSUING*****



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UNIwersytet Medyczny w Lublinie – Formularz Aplikacyjny na Rok 2020/2021

MOTHER'S NAME / IMIĘ MATKI:	*****MOTHER'S NAME*****
FATHER'S NAME / IMIĘ OJCA:	*****FATHER'S NAME*****
SOCIAL SECURITY NUMBER / NUMER SSN:	****SOCIAL***
E-MAIL ADDRESS / ADRES E-MAIL:	*****E-MAIL*****

PERMANENT ADDRESS / ADRES STAŁEGO ZAMIESZKANIA:

MAILING ADDRESS (omit if identical with the permanent address) / ADRES DO KORESPONDENCJI:

EDUCATION / WYKSZTAŁCENIE:

The type of high school diploma / rodzaj dokumentu potwierdzającego ukończenie szkoły średniej:

- International Baccalaureate (IB) / European Baccalaureate (EB)
 Other

The country in which you graduated from high school / kraj, w którym ukończono szkołę średnią:

- One of OECD, EU, or EFTA countries / Swiss Confederation
 Other

Completed secondary education / uzyskane wykształcenie średnie:

Type of school / rodzaj szkoły

School name (full name) / pełna nazwa szkoły

School location (full address with country) / pełny adres szkoły



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Date of graduation [dd-mm-yyyy] /data ukończenia

--

BMAT exam date (not older than from 2017) and score / data i wynik egzaminu BMAT (nie wcześniej niż 2017)

Exam date:	Score:

MCAT exam date (not older than from 2017) and score / data i wynik egzaminu MCAT (nie wcześniej niż 2017)

Exam date:	Score:

PRE-MED / PARAMEDICAL COLLEGE / WYKSZTAŁCENIE WYŻSZE PRZEDMEDYCZNE

SUBJECT	NAME OF COLLEGE	YEAR OF COMPLETION	NUMBER OF CREDITS	GRADE
BIOLOGY 1				
BIOLOGY 2				
BIOLOGY 3				
BIOLOGY 4				
GENERAL CHEMISTRY 1				
GENERAL CHEMISTRY 2				
ORGANIC CHEMISTRY 1				
ORGANIC CHEMISTRY 2				
PHYSICS				
MATHEMATICS				

LANGUAGE CERTIFICATE / PROOF OF PROFICIENCY IN ENGLISH (if applicable) / CERTYFIKAT JĘZYKOWY /

/ CERTYFIKAT JĘZYKOWY / POTWIERDZENIE ZNAJOMOŚCI JĘZYKA ANGIELSKIEGO (jeśli dotyczy)

--

ENTRANCE EXAM PREFERENCE /PREFERENCJA NA EGZAMIN WSTĘPNY

Standard MD Program – 6MD /Program Lekarski Standardowy

If you have obtained your high school diploma in a country not being a member state of the EU, OECD, EFTA, Swiss Confederation, and are not a holder of an IB/EB diploma, you will be required to take a written entrance exam. Biology is a mandatory subject. Please choose 2 electives out of the 3 below:

- Chemistry
- Physics
- Mathematics



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Advanced MD Program – 4MD /Program Lekarski Zaawansowany

You will be required to take a written entrance exam unless your MCAT score is at least 490. Biology is a mandatory subject. Please choose 2 electives out of the 3 below:

- Chemistry
- Physics
- Mathematics

TICK THE BOXES BELOW STATING THAT YOU ARE AWARE OF THE FOLLOWING

REGULATIONS ZAZNACZ ODPOWIEDNIE OKIENKA, JEŚLI ZAPOZNAŁEŚ/AŚ SIĘ Z PONIŻSZYMI INFORMACJAMI:

HIGH SCHOOL DIPLOMA NOSTRIFICATION / NOSTRYFIKACJA DYPLOMU UKOŃCZENIA SZKOŁY ŚREDNIEJ

I have acknowledged the rules of nostrification and I understand that if my high school documents have to be recognized in Poland, I shall be required to provide the University with the legalized original certificate/diploma or its certified duplicate and a certified translation into Polish to be further processed by the local education authorities. / Zapoznałam/em się z zasadami nostryfikacji i rozumiem, że w celu uznania w Polsce dokumentów potwierdzających moje wykształcenie średnie mam obowiązek dostarczyć Uczelni oryginał/kopię notarialną świadectw opatrzonych odpowiednią legalizacją/apostille oraz ich tłumaczenie na język polski do procesu nostryfikacji.

OBLIGATORY MEDICAL EXAMINATION FOR APPLICANTS/STUDENTS OF MEDICAL UNIVERSITY OF LUBLIN

/ OBOWIĄZKOWE BADANIA LEKARSKIE DLA KANDYDATÓW/STUDENTÓW NA UM

I understand that I am obliged to undergo mandatory health checkup by an occupational physician in Poland. I am acquainted with the relevant regulations / Rozumiem, że jestem zobowiązany/a odbyć obowiązkowe badania lekarskie w poradni medycyny pracy w Polsce. Zapoznałem się z obowiązującymi regulacjami.

I understand that I will not be allowed to enter any clinical class / clerkship if I fail to fulfill this obligation / Rozumiem, że nie będę mógł/mogła uczestniczyć w jakichkolwiek zajęciach klinicznych/wymagających kontaktu z pacjentem dopóki nie spełnię tego wymogu.

ANY SPECIAL NEEDS CONCERNING THE ENTRANCE EXAM SHOULD BE REPORTED TO THE DEAN'S OFFICE

AT LEAST 7 DAYS PRIOR TO THE EXAM DATE / WSZELKIE SZCZEGÓLNE POTRZEBY KANDYDATÓW PODCHODZĄCYCH DO EGZAMINU WSTĘPNEGO POWINNY ZOSTAĆ ZGŁOSZONE DO BIURA OBSŁUGI STUDENTÓW ANGLOJĘZycznych CO NAJMNIEJ 7 DNI PRZED DATĄ EGZAMINU.

FULL NAME /PEŁNE IMIĘ I NAZWISKO: _____

SIGNATURE /PODPIS: _____

DATE /DATA: _____



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CHECKLIST OF ATTACHED DOCUMENTS /LISTA ZAŁĄCZNIKÓW DO APLIKACJI

- High school diploma certified by the School/notary public (apostilled/legalized, if applicable);
- High school transcript certified by the School/notary public (apostilled/legalized, if applicable);
- Notarized black&white passport copy;
- Medical certificate confirming the absence of medical contradictions to study medicine;
- Hepatitis B vaccination certificate;
- Notarized black&white passport copy;
- Valid health insurance confirmation covering study in Poland;
- Document certifying the command of English, if applicable;
- College transcripts, if applicable;
- MCAT / BMAT score, if applicable.

INFORMATION FOR CANDIDATES ON PERSONAL DATA PROCESSING AT MUL / INFORMACJA DLA KANDYDATA ODNOŚNIE PRZETWARZANIA DANYCH OSOBOWYCH PRZEZ UNIWERSYTET MEDYCZNY W LUBLINIE:

I voluntarily submit my personal data during the application. I am aware that submitting data and participating in the application process depends on my decision, but failure to submit my personal data will exclude me from the application process.

The Medical University of Lublin, located at Aleje Raclawickie 1, 20-059 Lublin, further referred to as University or Controller, is the candidate's / student's data controller for data collected during the process of recruitment and fulfillment of the education process.

The University processes personal data for application purposes and, in case of admission, fulfillment of the education process and keeping academic records, including statutory (e.g. informing about scientific events), archival, and statistical purposes, as well as for assertion of claims if allowed by the provisions of law. Personal data may also be processed in connection with University monitoring according to the Controller's information on ensuring the safety and security of persons and property. Taking up studies and submitting personal data is voluntary, but necessary for the purposes for which the data have been collected.

The legal basis for the processing of candidate's / student's personal data is the Act of 20 July, 2018 - Law on Higher Education and Science (that is: Journal of Laws 2018, item 1668 as amended) and other provisions of law including regulations on the student records and, in case of historical data, Act on National Archive Resources and Archives, as well as the fact of signing an agreement with the University, therefore all the above has its basis in grounds referred to in art. 6, par. 1, let. b), c) and art. 9, par. 2, let. b) GDPR - General Data Protection Regulation and in carrying out tasks of public interest by the Controller or exercising of public authority entrusted to the Controller (art. 6, par. 1, let. e) GDPR).

The data will be processed only during the period of time necessary to complete the previously listed purposes as well as to clarify any doubts or potential claims connected with data processing within the time provided by law and in accordance with internal regulations of the University.

Processed personal data will not be sold or shared with third parties, with the exception of the entities authorized by legal provisions, including ones with relevant service agreements with the University, e.g. external services regarding IT support, handling correspondence, insurance, security.

Every candidate / student who submits his/her data has a right to:

- Access his/her personal data and receive their copy,
- Amend his/her personal data,
- Remove personal data in case its processing is not carried out in order to fulfil obligations resulting from the provisions of law or in the exercise of official authority
- Restrict the processing of personal data,
- Oppose data processing in cases provided for by the provisions of law
- Complain to the President of the Personal Data Protection Office.

Every student also has a right to exercise their rights by way of court proceedings.

In case of participating in voluntary extracurricular activities, which require a student's consent, a student has the right to revoke the authorization to process the data at any time, which will not affect the lawfulness of data processing before the revocation. He/she also has a right to demand to remove the data, or object to having them processed.



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The processed data will not be used for any purposes other than listed above. The data will not be used for profiling or processed by automated means. The person appointed by the data Controller for data processing supervision can be contacted at: iod@umlub.pl

The Data Protection Supervisor should be contacted only regarding the personal data processed by the University, including exercising the rights described above. The Data Protection Supervisor is not responsible for other issues, e.g. academic affairs or current correspondence with the University, which shall be directed to the addresses currently provided on the website. If you are interested in receiving information concerning events and initiatives of the University after the application process, circle the authorizations below according to your will. All authorizations are voluntary and can be revoked at any time, which, however, will not affect the legitimacy of data processing occurring beforehand. The processed data will not be used for any purposes other than listed in the authorization, they will be processed during the term of validity of the authorization, until the revocation or refusal of data processing. All information on data processing is included in the relevant clause on personal data

- I authorize/do not authorize [PLEASE CIRCLE ONE] the Medical University of Lublin, located at Aleje Racławickie 1, 20-059 Lublin, to process my personal data enclosed in the application form, now and in the future, for marketing and informative objectives.
- I authorize/do not authorize [PLEASE CIRCLE ONE] the Medical University of Lublin, located at Aleje Racławickie 1, 20-059 Lublin, to send unsolicited commercial communications, including commercial information, to my email address, pursuant to the provisions of “Ustawa o świadczeniu usług drogą elektroniczną” (Act on Rendering Electronic Services).
- I authorize/do not authorize [PLEASE CIRCLE ONE] the Medical University of Lublin, located at Aleje Racławickie 1, 20-059 Lublin, to send me marketing information with the use of telecommunications terminal equipment, pursuant to the provisions of “Ustawa Prawo telekomunikacyjne” (Telecommunications Act).

I acknowledge that the University shall not be liable for any incorrect personal data provided by the student

Date:

Full name:

Signature:

HOPE MEDICAL INSTITUTE

and Afiliated Universities

Medical University of Silesia | Medical University of Lublin

APPLICATION FOR EVALUATION AND ADMISSION



Preparing World Class Physicians Today, For Tomorrow

HOPE CENTER 11835 Rock Landing Drive

Newport News, VA 23606 USA

(757) 873-3333 | Fax: (757) 873-6661

Email: admissions@hmi-edu.org

www.hopemedicalinstitute.org

Checklist for Hope Medical Institute Application

The following documents are required in order to complete and process your application form.

Please make sure these documents are enclosed and/or being sent to Hope Medical Institute.

- Completed, signed application
- Two (2) Passport photos(*with your printed name and signature on back*)
- Two (2) original or notarized copies of your birth certificate(*Original birth certificates may be obtained from the Department of Health or Department of Vital Records in the state you were born in*)
- Two (2) notarized copies of your current passport page that shows date of birth
- Essay - "Why I want to become a physician"
- Two (2) official high school transcripts, sent in a sealed envelope from high school
- Two (2) notarized copies of high school diploma
- Two (2) official transcripts from each university attended, sent in a sealed envelope from university
- Two (2) notarized copies of all degrees you have received
- Two (2) official or notarized SAT and/or ACT scores (if the exam was taken)
- Two (2) official or notarized MCAT, VCAT and/or PCAT scores(*if the exam was taken*) (*MCAT scores are mandatory for all 4 year program applicants. MCAT scores must be submitted prior to August 15th for the fall program and prior to January 15th for the spring program*)
- Two (2) original, signed academic letters of recommendation
- \$75.00 USD non-refundable application fee(*made payable to Hope Medical Institute*)

Applicants may submit unofficial/student copies of transcripts for processing only. However, if admission is granted, official copies of transcripts are required to be sent in a sealed envelope (from the institution) to Hope Medical Institute. Transcripts downloaded from the internet will not be accepted. Letters of recommendation can be sent via e-mail by the author for processing only. All documents submitted become the property of Hope Medical Institute & its affiliated Universities and will not be returned.

All students who have attended college must provide a notarized copy of their High School diploma and official High School transcripts, sent in a sealed envelope (from the institution).

In addition, please make sure that your application form is completely filled out. Please submit two (2) current passport photos (with your printed name and signature on the back). **Do not tape, staple or glue your photo to the application form.**



**HOPE MEDICAL INSTITUTE
AND AFFILIATED UNIVERSITIES**

**DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY**

Hope Center
11835 Rock Landing Drive
Newport News, VA 23606 USA
Ph: (757) 873-3333 • Fax: (757) 873-6661
Email: admissions@hmi-edu.org
Website: www.hopemedicalinstitute.org

APPLICATION FOR EVALUATION AND ADMISSION

PHOTO

WITH STUDENT'S SIGNATURE
ON BACK OF PHOTO
ATTACH WITH PAPER CLIP
DO NOT TAPE, STAPLE,
OR GLUE PHOTO

In which semester are you applying for entrance? Fall (Oct) Spring (Feb) 20_____

MD Program DVM Program PharmD Program

Have you previously applied to HMI and Affiliated Universities? Yes No

Admission Granted Yes No If so, Where? _____

PERSONAL INFORMATION

1. _____
Last name First name Middle name

2. _____
Permanent mailing address

3. U.S. Citizen Resident Other
City, State, Zip Code, Country Visa status

4. _____ 5. _____ 6. _____
Last name First name Middle name

7. _____ 8. _____ 9. Male Female
Your E-mail address Country of citizenship Gender

10. Single Married Widowed Divorced 11. _____ 12. _____
Marital status Number of children Your occupation

13. _____
Applicant's father's name Occupation Age

14. _____
Applicant's mother's name Occupation Age

15. _____
Parent's mailing address Telephone Number

16. _____
Person to be notified in case of emergency Relationship Address Telephone Number

Date of graduation [dd-mm-yyyy] /data ukończenia

--

BMAT exam date (not older than from 2017) and score / data i wynik egzaminu BMAT (nie wcześniejszy niż 2017)

Exam date:	Score:

MCAT exam date (not older than from 2017) and score / data i wynik egzaminu MCAT (nie wcześniejszy niż 2017)

Exam date:	Score:

PRE-MED / PARAMEDICAL COLLEGE / WYKSZTAŁCENIE WYSZSZE PRZEDMEDYCZNE

SUBJECT	NAME OF COLLEGE	YEAR OF COMPLETION	NUMBER OF CREDITS	GRADE
BIOLOGY 1				
BIOLOGY 2				
BIOLOGY 3				
BIOLOGY 4				
GENERAL CHEMISTRY 1				
GENERAL CHEMISTRY 2				
ORGANIC CHEMISTRY 1				
ORGANIC CHEMISTRY 2				
PHYSICS				
MATHEMATICS				

LANGUAGE CERTIFICATE / PROOF OF PROFICIENCY IN ENGLISH (if applicable) / CERTYFIKAT JĘZYKOWY
/ / CERTYFIKAT JĘZYKOWY /POTWIERDZENIE ZNAJOMOŚCI JĘZYKA ANGIELSKIEGO (jeśli dotyczy)

3. Post Baccalaureate/Graduate Coursework Record (GPA=Grade Point Average, please enter numerical average or percentile.)



COURSE TITLE (INCLUDE LABS)	YEAR TAKEN		Credit Hours		Letter Grade		GPA	INSTITUTION
		LECTURE	LAB	LECTURE	LAB	LECTURE	LAB	

4. Cumulative Grade Point Averages (GPA=Grade Point Average, please enter numerical average or percentile.)

YEAR/PROGRAM	SCIENCE GP	NON SCIENCE GP	CUMALATIVE GP
High School (<i>Secondary education</i>)			
1st Year Undergraduate			
2nd Year Undergraduate			
3rd Year Undergraduate			
4th Year Undergraduate			
Cumulative Undergraduate			
Post Baccalaureate			
Graduate			

5. Standardized Test Scores (Please indicate your highest score for each test/subject.) *MCAT scores are mandatory for all 4 year program applicants and must be submitted prior to August 15th for the fall program and prior to January 15th for the spring program*

TEST	DATE	MCAT/VCAT/PCAT ONLY					SAT & ACT ONLY					
		VR	PS	WS	BS	QUANT.	VERBaAL	MATH	MATHIC	SCIENCE	OTHER	QUANT.
MCAT/VCAT												
PCAT												
SAT												
SAT II												
ACT												

Currently registered to take the MCAT/VCAT/PCAT on (Date): _____

6. Academic Honors (please list): _____

7. Scholarly Publications (please list): _____

8. Please list languages in which you are proficient: _____

9. Activities — In-School (please list): _____

Out-of-School (please list): _____

EMPLOYMENT EXPERIENCE



Please list all jobs held in the last five years. (Attach an additional sheet, if necessary.)

EMPLOYER'S NAME	ADDRESS	DATES OF EMPLOYMENT	OCCUPATION/DUTIES

HEALTH STATUS

Do you have any medical or physical health problems which may restrict you from fulfilling your educational responsibilities in the program which you are applying for? Yes No

If yes, please explain in detail on a separate sheet.

NATIONALITY/ETHNIC BACKGROUND (OPTIONAL)

- African American Hispanic or Latino
 Native American Caucasian
 Asian Other _____

WHERE DID YOU FIRST HEAR ABOUT HOPE MEDICAL INSTITUTE?

- Health Professions Advisor (name and school) _____
 Medical Professional (name) _____
 Family Member (name) _____
 Friend (name) _____
 HMI Applicant (name) _____
 HMI Current Student (name) _____
 HMI Graduate (name) _____
 Newspaper (name) _____
 Magazine (name) _____
 Email _____
 FaceBook _____
 YouTube _____
 MySpace _____
 Grad Fair (where?) _____
 Internet Search Engine _____
 Internet Site (name of site) _____
 Letter _____
 Med School Poster (Where?) _____
 Open House Event (Where?) _____

ADDITIONAL INFORMATION

1. Please list name and academic rank of the persons who will be submitting recommendations on your behalf

2. Have you ever been dismissed/expelled and/or required to withdraw from school for any reason Yes No (If yes, please explain in detail — attach an additional sheet if necessary):

3. Have you ever been convicted of a felony? Yes No (If yes, please explain in detail — attach an additional sheet if necessary):

FINANCIAL INFORMATION

In the best interest of the students, a comprehensive financial plan is required. Please enter the appropriate sources for the total cost per academic year. Students are required/expected to secure adequate financial assistance prior to attending any of our affiliated medical programs. Hope Medical Institute (HMI) and its affiliated Universities do not guarantee the availability of financial aid to any entering nor to any continuing students during their entire education period. Hope Medical Institute reserves the right to require proof of a student's ability to fund his/her complete education.

Self \$ _____ Financial Aid (Student Loans) \$ _____
Family \$ _____ Other \$ _____
Relatives & Friends \$ _____ Total \$ _____

STATEMENT OF AUTHENTICITY & DISCLAIMER

by completing and signing this form, I acknowledge and understand that withholding information requested in this application or giving false information may make me ineligible for admission to or continuation to any University affiliated with Hope Medical Institute. With this in mind, I certify that the above statements and any information provided to Hope Medical Institute is true, correct, and complete.

Hope Medical Institute does not guarantee or promise employment during any student's education or upon graduation. Furthermore, Hope Medical Institute does not guarantee transferability of the degree/diploma, granted by our affiliated medical Universities, from Poland to any other country. The programs offered by our affiliated Universities are currently recognized in USA, Canada and many other parts of the world; however, students wishing to practice in a country outside Poland should obtain information from the licensing authorities of the desired country for the suitability of the degree awarded by Hope Medical Institute's affiliated medical Universities.

If admission is granted, the university has the right to revoke the student's admission at any time prior to commencement of classes without providing any explanation to the student if it deems necessary to do so.

By application and acceptance, I give permission to Hope Medical Institute to use photos of myself in any promotional materials that enhance Hope Medical Institute and its affiliated University images. I also understand that all documents submitted become the property of Hope Medical Institute & its affiliated Universities and will not be returned to me.

I understand that I must pay a non-refundable fee of \$75 to Hope Medical Institute and affiliated Universities for processing my application which I will be paying by Credit Card Check (please check one)

I give permission to Hope Medical Institute and affiliated Universities to charge my credit card for application fee purposes only by initialing this statement here. Credit Card _____ (Please see attached credit card form)

I understand and agree to all of the information stated above.

Print Name

Signature of Applicant

Date (MM/DD/YYYY)

DO NOT WRITE IN THIS SPACE – FOR OFFICIAL USE ONLY

Date Application Received: ***** _____

Application Fee: ***** _____

Application Reviewed By: a) ***** _____

Signature: ***** _____

b) ***** _____

Signature: ***** _____

c) ***** _____

Signature: ***** _____

Program: 4 year 6 year MD DVM PharmD

Interview

Interview Date: _____ Interviewed By: _____ Signature _____

Comments: _____

Ranking/Score: _____

Interview

Interview Date: _____ Interviewed By: _____ Signature _____

Comments: _____

Ranking/Score: _____

Overall Comments: _____

Overall Ranking/Score: _____

Committee Recommendation: Accept/Conditional Reject Defer Hold

Student Admitted directly into: 1st year 2nd year 3rd year 4th year 5th year 6th year

University: Silesia Lublin Bialystok

Final Decision: _____