Instructions for Completing the Application Form for the Master’s Degree Program in Clinical Research

- SAVE THE APPLICATION FORM ON YOUR COMPUTER BEFORE COMPLETING IT.
- BEGIN TYPING IN THE FIRST SHADED BOX.
- USE THE TAB KEY (NOT THE ENTER OR RETURN KEY) TO MOVE TO THE NEXT SHADED BOX.
- YOU MAY ALSO USE THE MOUSE TO MOVE TO ANY SHADED BOX AT ANY POINT.
- USE THE MOUSE TO CLICK ON THE CHECK-BOXES (☐)

Application Check List

☐ Application Form for Master’s Degree Program in Clinical Research
    (Mail to the address below. Please also email to TICR_Admissions@psg.ucsf.edu)

☐ Official transcripts from all institutions attended after high school (secondary school), including any schools you are currently attending.
    (Request the respective institutions to submit official signed/stamped copies of your transcripts to the address below)

☐ Three letters of recommendation
    (Request the references to submit their letters directly to the address below or by e-mail to TICR_Admissions@psg.ucsf.edu)

☐ Official Test of English as a Foreign Language (TOEFL) scores. Request that the TOEFL/TSE services (www.toefl.org) send official score report to UCSF. Use recipient code 4840. The TOEFL is required of applicants whose education has taken place in a non-English speaking country.

Send materials to:
Admissions
Training in Clinical Research (TICR) Program
Department of Epidemiology and Biostatistics
University of California, San Francisco
Mission Hall (UCSF Box 0560)
550 16th Street, 2nd floor
San Francisco, CA 94143
(For FedEx only, use 94158)

Contact Phone/Fax:
415-514-6399 (telephone)
415-514-8150 (fax)

Initial Application: ___________________________ 
Undergraduate Transcript: ___________________________ Ref 1: ___________________________ TOEFL: _______ or ☐ Not Applicable
Graduate Transcript: ___________________________ Ref 2: ___________________________ 
Professional School Transcript: ___________________________ Ref 3: ___________________________ Application Complete: 

For Administrative Use Only: Dates Materials Received

v.10/23/2017
Application Form
Master’s Degree Program in Clinical Research

Personal Information:

| Last Name (Surname) | First Name (Given Name) | Middle Initial | Date of Birth
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<tr>
<th>Home Address</th>
<th>City</th>
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<tr>
<th>State/Province</th>
<th>Zip Code</th>
<th>Country</th>
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<tr>
<th>Best Phone Number to Reach You</th>
<th>Personal Email Address</th>
<th>Work Email Address</th>
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<tr>
<td>(include area code in the US; add country code if not in US):</td>
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<table>
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<tr>
<th>Degrees</th>
<th>Countries in which you have Citizenship</th>
</tr>
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Note: We ask questions about sex, gender, race and ethnicity both because we are interested in the diversity of our students and because we are often asked by our funders and regulatory bodies.

What sex were you assigned at birth, on your original birth certificate?  
☐ Male  ☐ Female

How do you describe your gender identity?  
☐ Male  ☐ Female  ☐ Other (specify)

Gender identity refers to a person’s internal sense of themselves (how the feel inside) as being male, female, transgender, or another gender.  This may be different or the same than a person’s assigned sex at birth.

Do you consider yourself of Hispanic/Latino ethnicity*?  
☐ Yes, I am from Hispanic/Latino ethnicity  ☐ No, I am not from Hispanic/Latino ethnicity  ☐ Prefer not to answer

*We are following the classification of the U.S. National Institutes of Health, which defines Hispanic/Latino ethnicity as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

What race* do you consider yourself?  Mark all that apply

☐ American Indian/Alaska Native  ☐ Black or African American  ☐ White

☐ Asian  ☐ Native Hawaiian or Other Pacific Islander  ☐ Prefer not to answer

*We are following the classification of the U.S. National Institutes of Health, which defines the following racial groups:
• American Indian or Alaska Native: A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliations or community attachment.
• Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
• Black or African American: A person having origins in any of the black racial groups of Africa.
• Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
• White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Positions and Institutional Affiliations:

Are you already currently enrolled in a program in the UCSF Graduate Division?  
☐ No
☐ Yes

⇒ What kind of program:  
☐ Credit-bearing Certificate Program  ☐ Master’s Program  ☐ PhD Program

⇒ Name of your program:  


Other than the UCSF Graduate Division, do you currently have a position at UCSF (e.g., professional student, clinical trainee, staff member, faculty member)?

- [ ] No
- [ ] Yes

Choose from the following list

<table>
<thead>
<tr>
<th>Your Position at UCSF</th>
<th>Specify other Position</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Department</td>
<td>Division</td>
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</tbody>
</table>

Other than the UCSF Graduate Division (or this Master’s Program to which you are applying), will you have a position at UCSF at the time of enrollment into the Master’s Program (e.g., professional student, clinical trainee, staff member, faculty member)?

- [ ] No
- [ ] Yes

Choose from the following list

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Do you currently have a position/affiliation with an institution aside from UCSF (e.g., another college/university, medical center, governmental agency, foundation, or private industry)?

- [ ] No
- [ ] Yes

Name of the Other Institution  
City  
Country  
Position  
School (e.g., Medicine, Dentistry)  
Department  
Division

Will you have a position/affiliation with an institution aside from UCSF at the time of enrollment into the Masters Program (e.g., another college/university, medical center, governmental agency, foundation, or private industry)?

- [ ] No
- [ ] Yes

Name of the Other Institution  
City  
Country  
Position  
School (e.g., Medicine, Dentistry)  
Department  
Division

**Anticipated Research Mentors During the Master’s Program:**
Leave blank if you are originating from outside UCSF and are in the process of identifying a mentor.

Anticipated Research Mentor #1:

<table>
<thead>
<tr>
<th>Last Name (Surname)</th>
<th>First Name</th>
<th>Institution</th>
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School  
Department  
Division (if applicable)

Anticipated Research Mentor #2:

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School  
Department  
Division (if applicable)
**Education:** list all undergraduate, graduate, and professional schools attended in chronological order. If there are more than 5, please list in the Optional Additional Information page.

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<tr>
<th>Institution</th>
<th>Location</th>
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<tr>
<td>Dates of Attendance</td>
<td>Major Field of Study</td>
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**Post Graduate Training:** include internships, residencies, fellowships, and other appointments. If there are more than 5, please list in the Optional Additional Information page.

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### Academic Honors, Honorary Societies, and Awards:

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<th>Date</th>
<th>Title/Description</th>
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### Research Experience: include major clinical and laboratory research experiences (full and part-time).

1.  
   - **Position**:  
   - **Institution**:  
   - **Preceptor’s Name**:  
   - **Project Title**:  
   - **Dates**:  

2.  
   - **Position**:  
   - **Institution**:  
   - **Preceptor’s Name**:  
   - **Project Title**:  
   - **Dates**:  

3.  
   - **Position**:  
   - **Institution**:  
   - **Preceptor’s Name**:  
   - **Project Title**:  
   - **Dates**:  

4.  
   - **Position**:  
   - **Institution**:  
   - **Preceptor’s Name**:  
   - **Project Title**:  
   - **Dates**:  

5.  
   - **Position**:  
   - **Institution**:  
   - **Preceptor’s Name**:  
   - **Project Title**:  
   - **Dates**:  

### Board Certification Status: include Specialties (e.g., Internal Medicine, Pediatrics) and Sub-Specialties (e.g., Infection Diseases, Cardiology)

- No
- Yes

```plaintext
#1: Field: ________________________________  
In which country? ____________________________  
Taken the exam?:  
☐ Yes ☐ No  
- exam taken, awaiting report  
- failed exam  
- board certified – year:  

#2: Field: ________________________________  
In which country? ____________________________  
Taken the exam?:  
☐ Yes ☐ No  
- exam taken, awaiting report  
- failed exam  
- board certified – year:  
```
Objectives:
Please describe your reasons for interest in the program. Include your objectives, clinical and research interests and goals, and how acceptance into the program can help you accomplish these. Please limit your response to this page.
Optional Additional Information:

Please use the following space to tell us anything else you would like us to know about your background, experience, or objectives. Please limit to one page.
References:
List three individuals whom you have asked to send letters of reference. If you are affiliated with UCSF, one letter should be from the Program Director of your current training program (if you are a Resident, Fellow or a pre-doctoral student in a research fellowship), your Division Chief or Department Chairperson (if you are a faculty member), your Faculty Advisor (if you are pre-doctoral outside of a fellowship or a graduate student), or equivalent. If you are otherwise unaffiliated with UCSF, please obtain these letters from a current or recent instructor, advisor, or supervisor. Please provide each reference with one of the recommendation forms that are posted on the program website.

1. Name ___________________________________________ Position/Title ___________________________
   Institution ____________________________________________________________

2. Name ___________________________________________ Position/Title ___________________________
   Institution ____________________________________________________________

3. Name ___________________________________________ Position/Title ___________________________
   Institution ____________________________________________________________

How did you learn about our program? Mark all that apply:
☐ You know one or more of our current or former students
   Which ones (optional?): ______________________________________________________
☐ Your advisors told you about it
☐ You performed an internet search
☐ You saw an ad on: ☐ Facebook ☐ Another website (which one?): ______________________

Signature (please sign the hard-copy version of this application):
________________________________________________________________________

Date of Application:   /  /
mmm/dd/yyyy

Social Security Number: Include this ONLY on the hard copy of the application that you sign: ______________________

Are you applying for the combined MD/MAS Program? ☐ Yes ☐ No

In addition to this application form and three letters of references, please arrange to have official sealed transcripts from all undergraduate, graduate, and professional schools sent to the address below. If applicable, please arrange to have your official TOEFL scores sent to UCSF. Use recipient code 4840.

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