REQUIRED APPLICATION
AND PROGRAM
DOCUMENTS
Maternal & Child Health Leadership Education in Neurodevelopmental & Related Disabilities Program
University of Hawai‘i at Mānoa • John A. Burns School of Medicine • Department of Pediatrics

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PROGRAM REQUIREMENTS

The Hawai‘i MCH LEND Program (HIMCHLEND) is a federally-funded program through the Health Resources and Services Administration (HRSA) Maternal Child Health Bureau (MCHB) since 1994. We appreciate your interest and look forward to receiving your application. Thank you for your time and consideration!

The follow checklists enumerates both application and participation requirements for Trainee candidates of the Hawai‘i MCH LEND Program. For application purposes, please submit the completed forms and corresponding documents required in the Application Requirements Section via mail by April 15, 2013 to:

MCH LEND Program  
Department of Pediatrics  
Kapi‘olani Medical Center  
1319 Punahou Street, Room 745  
Honolulu, Hawai‘i 96826

Once selected as a Trainee you will have until June 1, 2013 to submit the required documentation.

If you have questions or comments, please contact the MCH LEND Program office at (808)956-3142 or send an email to mchlend@hawaii.edu.

APPLICATION REQUIREMENTS

To be considered as a candidate for the MCH LEND Program you must meet or exceed the following criteria and submit the required documentation by April 15, 2013:

Minimum criteria:
- US citizen or permanent resident visa status
- Advanced graduate student standing (Academic trainee)
- Completion of basic clinical training as required in discipline
- Demonstration of excellence in foundation courses within discipline

Desirable criteria:
- Demonstrates experience with individuals with disabilities and/or children with special health care needs and family members
- Demonstration of career goals to work in the area of maternal and child health with individuals with disabilities and families
Required Documentation:
- Completed application form
- Nomination form from supervisor/department faculty
- Resume
- Copy of recent applicable certifications and licenses
- Proof of malpractice insurance coverage
- Three (3) letters of recommendation from supervisory persons and/or faculty

PARTICIPATION REQUIREMENTS

Upon acceptance into the program, trainees submit the required documentation by June 1, 2013:

Health requirements:
- Proof of current professional or student liability insurance coverage
- Immunization records or positive titer or medical record of disease for:
  - Hepatitis B
  - Varicella
  - Rubeola (Measles)
- Positive titer for Rubella (German Measles) – 2 vaccines required if blood test is negative or equivocal
- 2-step PPD results within 1 year from application. Please provide ONE of the following options:
  - A two-step Mantoux tuberculin skin test (Two TB skin tests completed one week apart) within 90 days before start date.
  - A single TB skin test may be submitted if you provide documented medical record of a negative TB skin test performed within the previous twelve (12) months or documented medical records of a prior negative 2-step TB skin test.
  - If you provide documented medical record of a previous positive tuberculin skin test and documented medical record of a negative standard chest x-ray (done within the past year), no additional skin test or chest x-ray is needed. Only a TB screening questionnaire is required. Please contact the MCH LEND Program office to obtain the form.
**APPLICATION FORM**

*Academic Year 2013-2014*

**Directions:**

1. Print the form and complete the information below.
2. Print and submit the completed form by mail to: MCH LEND Program, Kapiʻolani Medical Center, 1319 Punahou Street, Room 745, Honolulu, Hawaiʻi 96826
3. You will be given priority consideration if your Application Form is submitted by April 15, 2013.
4. If you have questions or comments, contact the MCH LEND Program office at (808)956-3142 or send an email to mchlend@hawaii.edu

Trainees may be eligible for stipends. The availability of stipends each year is dependent upon the federal funds received by the program.

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<tr>
<th>LEGAL NAME: FAMILY/LAST</th>
<th>FIRST/GIVEN</th>
<th>MIDDLE</th>
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<tr>
<th>CURRENT MAILING ADDRESS – NUMBER AND STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
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<th>HOME PHONE</th>
<th>CELL PHONE</th>
<th>PAGER</th>
<th>OTHER</th>
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<th>EMAIL ADDRESS</th>
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The MCH LEND Program must report to several federal agencies summary data on the gender and ethnic background of its applicants. Therefore, it is required that each person applying for admission to the MCH LEND Program indicate his or her gender and ethnic background on the application form. This information does not affect determination of admission.

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<tr>
<th>GENDER</th>
<th>BIRTHDATE MONTH/DAY/YEAR</th>
<th>ETHNICITY (LIST ALL)</th>
<th>CITIZENSHIP</th>
<th>NON-US CITIZEN VISA TYPE</th>
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<td></td>
<td></td>
<td>USA</td>
<td>STUDENT VIA</td>
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<td></td>
<td>OTHER (SPECIFY)</td>
<td>PERMANENT RESIDENT</td>
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<td>OTHER (SPECIFY)</td>
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**ACADEMIC TRAINEE (matriculated student) OR POST-DOCTORAL FELLOW APPLICANTS ONLY:**

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<th>INDICATE YOUR STUDENT STATUS:</th>
<th>DEGREE SOUGHT AND EXPECTED YEAR OF COMPLETION</th>
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**COMMUNITY TRAINEE APPLICANTS ONLY:**

| YOUR CURRENT POSITION/JOB TITLE: | |
|----------------------------------| |

| YOUR CURRENT EMPLOYING AGENCY: | |
|---------------------------------| |

**LIST YOUR EDUCATION HISTORY**

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<tr>
<th>INSTITUTION</th>
<th>YEARS ATTENDED</th>
<th>DEGREE CONFERRED</th>
<th>MAJOR</th>
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</table>
Please briefly answer the following questions. Attach an additional sheet if necessary.

Briefly summarize your background in terms of maternal and child health experiences:

Briefly summarize your background related to children with special health care needs and individuals with disabilities:

What are your goals for participation in the MCH LEND Program?

What are your career goals related to children with or at risk of disabilities, family members and community health services?

**APPLICANT’S CERTIFICATION**

I certify that the responses provided on the MCH LEND Application Form are complete and true to the best of my knowledge and belief. I understand that providing incomplete, incorrect, or false information may result in the recession or denial of my admission. Further, I understand that the MCH LEND Program shares a common database with the Association of University Centers on Disability and summary data pertaining to students in the MCH LEND training Program may be accessed.

APPLICANT’S SIGNATURE ____________________________ DATE ________________

**HAWAI‘I MCH LEND OFFICE USE ONLY**

<table>
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<tr>
<th>Date received:</th>
<th>Faculty Mentor:</th>
<th>Acceptance status:</th>
<th>Stipend amount:</th>
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</table>
SUPERVISOR/DEPARTMENTAL NOMINATION

Directions:
1. Academic trainees and Fellows must be nominated by a supervising faculty. Community trainees must be nominated by their supervisor.
2. Final decisions regarding acceptance, funding levels for trainees, and training activities will be conducted with the faculty representatives from the MCH LEND Program.
3. Submit the completed form by mail to:
   MCH LEND Program, Department of Pediatrics, Room 745
   Kapi‘olani Medical Center, 1319 Punahou Street, Honolulu, Hawai‘i 96826
4. If you have questions or comments, please contact the MCH LEND Program office at (808)956-3142 or send an email to mchlend@hawaii.edu

Name of applicant: ___________________________ Date: ________________

Supervising faculty to supply the following information for ACADEMIC TRAINEES

Name of Faculty Sponsor: ___________________________

Department: _____________________________________

Address: _______________________________________

City: __________________ State: __________ Zip: __________

Email Address: ___________________________________

Work Phone: __________ Fax: __________ Other: __________

督导签署： ___________________________________ 日期： ________________

Direct Supervisor to supply the following information for COMMUNITY TRAINEES

Name of Supervisor: ___________________________

Organization: _________________________________

Address: _____________________________________

City: __________________ State: __________ Zip: __________

Email Address: ___________________________________

Work Phone: __________ Fax: __________ Other: __________

督导签署： ___________________________________ 日期： ________________
REFERENCE FORM

Section A
(TO BE COMPLETED BY THE APPLICANT)

Applicant’s Directions:
1. **Print three (3) copies of this Form.**
2. Fill-in all the information for Section A (Applicant’s information) and check the appropriate line for authorization and waiver.
3. Sign at the line for applicant.
4. **Give a copy of the ENTIRE FORM (both sections A and B) to three (3) reviewers.**

<table>
<thead>
<tr>
<th>Name of applicant:</th>
<th></th>
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Name of person supplying recommendation: __________________________________________

Reviewer’s Title: ___________________ Reviewer’s Position: _________________________

Reviewer’s Department/Organization: _____________________________________________

Select one of the following:

☐ I hereby waive any and all rights to access to confidential letters pertaining to this application. I understand that the completed form will be held in confidence from me and the public by the University of Guam and the University of Hawai‘i at Mānoa.

☐ I do not waive my rights to access to this recommendation but I authorize the reference to provide a candid evaluation and all relevant information to the University of Guam and the University of Hawai‘i at Mānoa.

Applicant’s signature: ___________________ Date: ______________

Give one copy of this entire form (Section A and Section B) to each reviewer.
Section B
(TO BE COMPLETED BY THE REVIEWER)

Reviewer’s Directions:

1. Provide your estimate of the applicant’s ability to pursue and to complete a leadership training curriculum in Maternal and Child Health. Submit the completed form by mail to:
   MCH LEND Program, Department of Pediatrics, Room 745
   Kapi‘olani Medical Center, 1319 Punahou Street, Honolulu, Hawai‘i 96826
2. If you have questions or comments, please contact the MCH LEND Program office at (808)956-3142 or send an email to mchlend@hawaii.edu

Name of Applicant: ____________________________
Name of Reviewer: ____________________________  Reviewer’s Position: ____________________________

Please rate the applicant on the following achievements and characteristics (check only one from each criterion):

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Unable to Judge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to express himself/herself in speech and writing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Self-reliance and independence</td>
<td>☐</td>
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<tr>
<td>Maturity</td>
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<tr>
<td>Flexibility</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Social Sensitivity</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>Ability to work with others who have different viewpoints</td>
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<td>☐</td>
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<td>Growth during total period of observation</td>
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<td>☐</td>
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<tr>
<td>Reliability and follow-through</td>
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Comments:

In what capacity do you know the Applicant:

Reviewer’s signature: ____________________________  Date: ____________________________
Reviewer’s phone number: ____________________________
IMMUNIZATION AND OTHER HEALTH REQUIREMENTS

Health clearance and personal liability coverage is required for trainees to participate in the Advanced Clinical Training component of the MCH LEND Program. All documentation of coverage must be approved by the first day of the Clinical experience.

Written documentation must be provided for vaccinations received or documentation of a positive titer is required. Photocopies of previous documentation are acceptable. Provide documentation as listed on the following Kapi‘olani Medical Center clearance form as shown below.

Checklist for Health Requirements

Upon acceptance into the program, trainees who are participating in the program will need to provide:

- Proof of current professional or student liability insurance coverage
- Immunization records or positive titer for:
  - Hepatitis B
  - Varicella
  - Rubeola (Measles)
- Positive titer for Rubella (German Measles) – 2 vaccines required if blood test is negative or equivocal
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2. If you have questions or comments, please contact the MCH LEND Program office at (808)956-3142 or send an email to mchlend@hawaii.edu.