



Authorization for the Release of Personal Information

HEALTH PROFESSIONS OFFICE

Terms

I authorize the Texas A&M University - Corpus Christi's Health Professions Advising Committee (HPAC) and its representatives, agents, and designees to release a letter of evaluation following review and deliberation by HPAC of my pre-medical or pre-dental application materials.

I consent to request for inspection of and discussion about information by members of the HPAC who may be responsible for the evaluation of my progress, qualifications, judgment, and competency regarding the practice of medicine or dentistry.

I have been informed that my file will include the following:

1. A personal statement written by me in which I detail my desire to practice within my chosen health profession (i.e. medicine, dentistry, or etc.) and to provide aspects of my background that make me a suitable candidate.
2. Three to five confidential letters of recommendation written of my behalf, two of which are strongly suggested to be from full-time science professors at Texas A&M University - Corpus Christi (University); and
3. A complete and up-to-date list of science courses taken by me detailing grades received in those courses, including my math and science (BCPM) grade point average and cumulative grade point average.
4. The "Statement of Responsibility" indicating I will provide my necessary pin numbers and letter request emails prior to June 1st.
5. A resume that includes a color photograph of headshot.
6. Scores from either a completed full practice or actual required admission exam from my chosen health profession.

I understand that HPAC may also consider other circumstances, opinions, and assessments relevant to my case including, but not limited to

1. My ability to communicate and to work effectively with others;
2. Any corrective or disciplinary action concerning me during the time I have been enrolled at the University;
3. My judgment, character, and ethical qualifications; and
4. Any other matters the HPAC member feel are or may be relevant to my fitness to practice medicine or dentistry.

I expressly give permission for letters of recommendation to be released in accordance with my completion of a *Request for Mailing Letters of Evaluation* form. I also authorize the release of information that supplements, updates, or supersedes information contained in any letters of recommendation whether this update information is sent as a result of my request or by initiative of HPAC or the University.

To the extent permitted by law, I waive all provisions of law, including provisions of the Family Educational Rights and Privacy Act (FERPA) that do or may relate to the disclosure of this information. I further release and hold harmless HPAC and its members and agents, Texas A&M University - Corpus Christi, the Texas A&M System's Board of Regents, faculty, employees, agents, and personnel from and against any liability that might otherwise arise from release of this information.

Signature

I agree to the conditions outlined in the terms above and hereby authorize HPAC to evaluate my credentials.

Signature: _____ Date: _____



HEALTH PROFESSIONS OFFICE

A. Applicant Information

Full Name: Last First M.I. A#:

Address: Street Address Apartment/Unit #

City State ZIP Code

Cell Phone: Islander Email:

Preferred Email:

Application to: Cumulative GPA: BCPM GPA:

Major: Are you a post-Baccalaurate? Insert color photo below (<150 kb)

Are you using Fresh Start?

MCAT Score Scaled %

Date Taken:

DAT Score AA %

Date Taken:

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: Date:



B. Source of Coursework

Colleges/Universities Attended (chronological)	BCPM GPA	Degree Earned	Dates Attended	Credit Hours	Cumulative GPA

	BCPM GPA	BCPM Hours	Cumulative GPA	Cumulative Hours
Undergraduate				
Post-baccalaureate				
All Pre-graduate (UG + PB)				
Graduate				

C. Required BCPM Coursework

Course Subject	Course #	Where Taken	Grade	Point Value	Credit Hours	Grade Value (Point value x Credit Hours)	Click if Repeated
Biology I							
Biology I lab							
Biology II							
Biology II lab							
Genetics							
Biochemistry							
Chemistry I							
Chemistry I lab							
Chemistry II							
Chemistry II lab							
Org Chemistry I							
Org Chemistry I lab							
Org Chemistry II							
Org Chemistry II lab							
Physics I							
Physics I lab							
Physics II							
Physics II lab							
Statistics							



HEALTH PROFESSIONS OFFICE

J. List of LoRs

You must have a minimum of 3 letter writers for review and a maximum of 5 letter writers. 2 of these must be BCPM Professors at Texas A&M University - Corpus Christi. Please list the individuals who have agreed to write a letter in support of your application to medical/dental school. For each letter writer, please include their contact information and your rationale for selecting this individual as a letter writer.

BCPM Professor (Texas A&M University - Corpus Christi) 1

Title	First name	Last Name	Department
Email		Phone	

Rationale for selecting this letter writer.

BCPM Professor (Texas A&M University - Corpus Christi) 2

Title	First name	Last Name	Department
Email		Phone	

Rationale for selecting this letter writer.

Wildcard Letter Writer 1

Title	First Name	Last name	Relationship

Organization (and address)

Email		Phone	

Rationale for selecting this letter writer.



HEALTH PROFESSIONS OFFICE

Wildcard Letter Writer 2

Title	First Name	Last name	Relationship

Organization (and address)

Email	Phone

Rationale for selecting this letter writer.

Wildcard Letter Writer 3

Title	First Name	Last name	Relationship

Organization (and address)

Email	Phone

Rationale for selecting this letter writer.



COLLEGE OF
SCIENCE AND
ENGINEERING



Statement of Responsibility

HEALTH PROFESSIONS OFFICE

Statement of Responsibility

Statement of Responsibility

Name & Date

Applicant's Name

Date