

Dear M*A*S*H Applicant,

The Medical Application of Science for Health (M*A*S*H) Program is a two week long intensive summer program for high school students who will be **entering their junior or senior year** in the Fall 2025

The M*A*S*H Program is sponsored and funded by North Arkansas Regional Medical Center (NARMC), the University of Arkansas for Medical Sciences and the Arkansas Farm Bureau. **There is no charge to attend the program.**

An integral part of the M*A*S*H experience is exposure to the differing areas of medicine and the variety of health-related professions. Students will learn to identify some of the various health care disciplines, what they do, how they relate to one another, and how the fundamentals of anatomy, biology, pharmacology, and physiology are employed in each discipline. The basic science connections to medical diagnosis and treatment will be reinforced through lecture presentations, labs, and clinical interactions. Additionally, students will be exposed to the importance of healthy lifestyle habits and will earn their certification in CPR & First Aid.

Students interested in participating in M*A*S*H must meet the following criteria:

1. Have completed a biology course **prior** to the start of M*A*S*H
2. Have a minimum of a 3.0 GPA
3. Demonstrate the ability to be task-committed and to utilize creative and critical thinking skills
4. Submit a completed application
5. Submit two (2) recommendations from school personnel, one of which must be from a teacher
6. Submit current vaccination record
7. Provide current TB skin test. Test must have been completed after July 1, 2024. If not already done before applying wait until acceptance and more information will be given.
8. Provide proof of COVID-19 vaccination or declination upon acceptance.
9. Face-to-face interview with NARMC M*A*S*H Program Director & Staff will occur after all potential applications have been reviewed.

The NARMC 2025 M*A*S*H Program will be held June 9th through June 20th.

If you meet the requirements and are interested in this summer's program, send your completed application and recommendation forms to:

**NARMC – Office of Employee Education and Training
620 North Main St.
Harrison, AR 72601**

DEADLINE FOR APPLICATIONS IS April 1, 2025. Applications received after April 1st will not be accepted. Letters notifying applicants of their acceptance or denial will be sent by May 1, 2025.

If you have any questions regarding NARMC's 2025 M*A*S*H program, please call (870) 414-4098.

Thank you,
Delbert McCutchen, MSN, RN, NRAEMT
Director, Office of Employee Education & Training

**M*A*S*H
STUDENT APPLICATION FORM**

STUDENT:

1. Name: _____
Last First Middle initial

2. Sex: _____ Race: _____ Date of Birth: _____ / _____ / _____

3. Social Security Number: _____ / _____ / _____ Nickname (if you use one): _____

4. Home Address: _____
Street or P.O. Box

City County Zip code

5. Home telephone number: _____ Cell phone number: _____
Area code/number Area code/number

6. Email Address: _____

7. High School : _____ Year you graduate: _____

8. School Mailing Address: _____
Street or P.O. Box City Zip Code

9. Shirt Size: Small Medium Large Extra Large Other:

PARENT or GUARDIAN:

10. Name: _____

11. Home Address: _____
Street or P.O. Box

City County Zip code

12. Home telephone number: _____ Work telephone number: _____
Area code/number Area code/number

13. Cell Phone Number: _____ Email Address: _____
Area code/number

14. List your significant SCHOOL achievements, awards, and accomplishments from the past two years.

15. List your significant NON-SCHOOL (community, church, etc.) achievements from the past two years. Also describe any jobs or duties you have at home or school that demonstrate your level of commitment to a task.

16. Please write in your own words why you are interested in attending M*A*S*H. Your response to this question is very important in the selection process. If you need more room, use one additional page and attach it to your application.

**M*A*S*H
STUDENT ACKNOWLEDGEMENT STATEMENT**

If accepted into the program, you agree to attend the full length of the program (2 week) and to abide by the following disciplinary policy.

DISCIPLINARY POLICY

The Education Staff will counsel a M*A*S*H participant if inappropriate behavior, poor performance, or poor attitude are reported. The participant will be counseled at the time of the report and if deemed necessary, may be dismissed from the program.

Certain behaviors will result in immediate dismissal from M*A*S*H and notification of your parent/guardian.

These behaviors include, but are not limited to:

- Inappropriate behavior, language or discussions
- Dishonesty affecting relationships or responsibilities
- Any degree of intoxication or possession of alcohol/drugs or weapons on hospital property
- Criminal charges or illegal possession of drugs, alcohol or weapons
- Breach of duty which is shown as a disregard for the well-being of our patients
- Any violation of HIPPA rules and regulations

Please note that this is a day program and that transportation to and from each daily session is your responsibility.

Signed: _____ Date: _____
Student

By entering your name, you acknowledge and agree as your signature.

PARENT/GUARDIAN PERMISSION STATEMENT

I/We hereby grant permission for my son/daughter to apply to this program and for school officials to report my child's achievement and grades. I/We will be responsible for his/her daily transportation for the week program. I/We understand that if my son/daughter is accepted, he/she will be expected to complete the full week program and to abide by the disciplinary policies.

Signed: _____ Date: _____
Parent/Guardian

By entering your name, you acknowledge and agree as your signature.

CONFIDENTIALITY AND HOLD HARMLESS AGREEMENT (MINOR)

As the undersigned parent(s) or legal guardian(s) of _____, a minor child, I (We) hereby consent to the participation of said child in the M*A*S*H Program at North Arkansas Regional Medical Center (NARMC). I (We) understand and agree that said child is to abide by all rules and requirements requested by NARMC and to conduct herself/himself in an appropriate manner.

I (We) understand that in the course of the child's participation in this program, he/she may have incidental exposure to confidential information. Confidential information includes all patient, employee, and student information and information of a proprietary, trade secret or otherwise confidential nature. I (We) agree that, during the child's participation in the program and after the conclusion of the program, said child will not disclose the confidential information to anyone, including myself/ourselves, in any way or in any form without the specific written authorization of NARMC except as may be required by law.

I (We) understand that there are certain risks inherent to and associated with the activities of any facility in which patient care and research are conducted. I (We) agree on behalf of said child to the assumption of those risks and not hold the NARMC or its officers, board members, agents or employees responsible for any harm or injury from any cause, which may befall said minor child related to or arising out of the child's participation in the program at NARMC, and hereby release said entities and persons from any liability relating thereto. I (We) further agree to indemnify and hold said entities and persons harmless from the claims or causes of action asserted by any other person on behalf of said child, or in their own right, arising out of said participation. I (We) similarly agree to hold said entities and persons harmless from the claims of other persons arising out of any acts done by me. I (We) understand and agree that this Agreement is not intended to include a release from harm caused by an individual's criminal conduct or by the conduct of an individual constituting an intentional tort recognized under Arkansas law; and any such criminal conduct or intentional tort is against NARMC policy and therefore outside the scope of the person's employment or relationship with NARMC for which NARMC is not vicariously liable. I (We) agree that these conditions and agreements are binding on all of my heirs, executors, administrators, representatives, assignees and successors in action.

I (We) have read and understand the above and willingly agree to said terms and conditions.

Signature _____ Date: _____

State relationship to child: _____

Signature _____ Date: _____

State relationship to child: _____

By entering your name, you acknowledge and agree as your signature.

**M*A*S*H
TEACHER RECOMMENDATION FORM**

INFORMATION PROVIDED WILL BE KEPT STRICTLY CONFIDENTIAL

1. **Student Name:** _____

First
Middle
Last
2. **School Name:** _____ **School District:** _____
3. **School Address:** _____

Street or P.O. Box
City
Zip Code
County
4. **This student must have completed Biology in order to be considered for the M*A*S*H Program.**
5. **Please state why you think this student would benefit from participating in the M*A*S*H Program. Comments should be made regarding the student's abilities and potential for success in a health care environment. Please use the space provided. If you need additional space, please attach a separate sheet. Please be sure to sign at the bottom of the page.**

Teacher's name: _____

By entering your name, you acknowledge and agree as your signature.

**M*A*S*H
COUNSELOR RECOMMENDATION FORM**

INFORMATION PROVIDED WILL BE KEPT STRICTLY CONFIDENTIAL

1. Student Name: _____
(First) (Middle) (Last)
2. School Name: _____ School District: _____
3. School Address: _____
Street or P.O. Box City Zip Code County
4. Please attach a legible transcript, including any citizenship courses, of the student's grades. This student must have completed Biology in order to be considered for the M*A*S*H Program.

I have discussed pertinent information on this form with this student and agree that he/she is genuinely interested in participating in the M*A*S*H Program.

Counselor's signature

Date

By entering your name, you acknowledge and agree as your signature.

Please include any additional information here from other faculty members that would assist the screening committee in making their selections.

**M*A*S*H
SHADOWING PREFERENCES FORM**

STUDENT NAME: _____

To assist in making the M*A*S*H Program most beneficial to you, please indicate below your particular areas of interest for shadowing.

Please select and rank in order your top four choices. **Rank choices 1 (first choice) to 4 (last choice).** Please feel free to write in any area of interest not listed.

	Critical Care/Intensive Care		Rehab Services/Physical Therapy/Occupational Therapy
	Dietary Services – Registered Dietician		Radiation Therapy
	Emergency Department		Surgery
	Emergency Medical Services (EMS)		Wound Care
	Home Care/Hospice	OFF CAMPUS OPPORTUNITIES	
	Imaging Department		Veterinarian
	Laboratory		Chiropractor
	Nursing Floors		Dentist’s Office
	OB/Women’s Health		Doctor’s Office
	Pharmacy`		Optometrist’s Office
	House Supervisor		

M*A*S*H Application Checklist

Please be sure the following forms are completed and returned to the NARMC Office of Employee Education and Training by April 1, 2025. You may drop off in person, mail, fax or email them. Forms received after April 1, 2025 will not be reviewed.

Face to face interviews for the program will be scheduled

**NARMC
Office of Employee Education and Training
620 N. Main St.
Harrison, AR 72601**

Fax – 870-414-4905

Email – education@narmc.com

- Student Application Form**
- High School Transcript showing completed Biology class and current GPA (Submit with Application)**
- Student Acknowledgement Statement (In Application)**
- Confidentiality and Hold Harmless Agreement (In Application)**
- Science Teacher Recommendation Form (In Application)**
- Teacher Recommendation Form (In Application)**
- Counselor Recommendation Form (In Application)**
- Shadowing Preferences Form (In Application)**
- Current vaccination records (Submit with Application)**
- Proof of COVID-19 vaccination or declination upon acceptance**
- Current TB skin test. Test must have been completed after July 1, 2024. (Upon acceptance more information about receiving TB test given)**