

# PREVIEW

## USE THIS FORM TO PREPARE YOUR PATHWAYS TO DISCOVERY APPLICATION

### Pathway to Discovery Enrollment Form

#### Instructions:

- This form is required to enter any Pathway to Discovery program.
- Save your work and return to this form by clicking "Save Answers and Resume Later" below. Your draft application can be saved for up to 21 days.
- Once submitted, your application cannot be modified, therefore, make certain to check your work. Preview the application requirements here.

#### Undergraduate Application Process:

1. Learner submits application.
2. Office of Undergraduate Medical Education verifies academic eligibility.
3. If required, mentor approves project plan.
4. Pathways to Discovery reviews application.
5. Decision letter emailed to learner and mentor.
6. Depending on your Pathway, a final, revised proposal may be required in Fall.

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#### Acknowledgment:

Before submitting your application, please review the program requirements linked below.

Required Components:

[Clinical and Translational Medicine](#)

[Global Health](#)

[Health Professions Education](#)

[Health and Society](#)

[Molecular Medicine](#)

Failure to complete program requirements within your specified project period will result in dismissal from the Pathways to Discovery program and notification to the Office of Undergraduate Medical Education.

I agree

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**PART 1: Contact, Demographic, and Academic Information**

## Pathway Program

Clinical and Translational Research  
Health and Society  
Health Professions Education  
Global Health  
Molecular Medicine

## MDwD Program

Yes  
No  
Undecided

**Applicant Information**

Learner's First Name  
Learner Middle Initial  
Learner Last Name\*  
Learner Email Address  
Learner Skype Name  
Personal Email Address (permanent)  
Primary Phone Number  
Alternate Phone Number  
Date of Birth  
Current degree/s\*  
MD  
MPH  
PhD (specify)  
MBA  
Other:

**Contact Information**

Current Mailing Address  
City  
State  
Zip Code  
Campus Box Number

Permanent Mailing Address  
City  
State  
Zip Code

**Emergency Contact Information**

Emergency Contact First Name

Emergency Contact Last Name  
Emergency Contact Email Address  
Emergency Contact Phone Number  
Emergency Contact Relationship to You

**Demographic Information**

Gender\*

Male  
Female  
Do not wish to provide

Citizenship\*

U.S. Citizen or Non-citizen National  
Permanent Resident of U.S.

Race/Ethnicity: Are you Hispanic (or Latino)\*

Yes  
No  
Intentionally withheld

What is your racial background?\*

(Check all that apply)

American Indian or Alaska Native  
Native Hawaiian or other Pacific Islander  
Asian  
Black or African American  
White  
Intentionally Withheld

Do you have a disability?

*(Disability: A physical or mental impairment that substantially limits one or two major life activities.)*

Yes  
No  
Do not wish to provide

Disability Detail:

Hearing  
Visual  
Mobility/Orthopedic  
Other

Are you from a disadvantaged background?

Yes  
No  
Do not wish to provide

Individuals falling in this category must have qualified for Federal disadvantaged assistance or have received Health Professional Student Loans (HPSL), Loans for Disadvantaged S Program, or scholarships from the U.S. Department of Health and Human Services under the Scholarship for Individuals with Exceptional Financial Need. 2. Comes from a family w annual income below established low-income thresholds, published by the U.S.

Bureau of the Census; adjusted annually for changes in the Consumer Price Index; and adjusted by Secretary for use in all health professions programs. The Secretary periodically publishes these income levels at <http://aspe.hhs.gov/poverty/index.shtml> 2. Comes from a social, c educational environment, such as that found in certain rural or inner-city environments, that has demonstrably and recently directly inhibited the acquisition of the knowledge, skills, abilities necessary to develop and participate in a research career. This category is most applicable to high school and perhaps undergraduate students, but more difficult to justify individuals beyond that level of achievement.

Is your research/scholarly project related to the health or health care of health disparities populations?

Yes

No

*If yes,*

You may be eligible for [Prof-Path](#), an innovative, NIH-funded opportunity if your research is related to health disparity populations or the care of health disparity populations OR you yourself come from a health disparity population which is defined by the NIH to include some ethnic minority, disability, and socio-economically disadvantaged learners.

Participant Benefits:

- NIH-funded research education and career development program for health professional students participating in mentored research;
- Dedicated monthly evening workshops focused on career development and leadership skill acquisition;
- Fellowships (summer, quarterly, year-long);
- Tuition/books/conference travel expenses;
- Research support.

Would you like a director to contact you regarding participation in Prof-Path?

Yes

No

### **Training Program Information**

UCSF School  
Medicine  
Nursing  
Dentistry  
Pharmacy  
Graduate

Expected Completion of Program

Planned specialty

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## **PART 2: Proposed Mentor, Project, and Application**

### **Proposed Mentors:**

#### **NOTE:**

*For the **Health Professions Education** Pathway, mentor support is strongly preferred. If you do not have an identified mentor yet, enter TBA below and use [TBA@ucsf.edu](mailto:TBA@ucsf.edu) in the email field.*

**For Health & Society Pathway**, mentor support is required to complete this application.

For **Molecular Medicine Pathway**, mentor support is required to complete this application.

For **Global Health Pathway**, mentor support is strongly preferred. If you do not have an identified mentor yet, enter TBA below and use TBA@ucsf.edu in the email field.

For the **Clinical and Translational Medicine Pathway**, mentor support is required to complete this application.

Mentor First Name (required)  
Mentor Last Name (required)  
Mentor Institutional Affiliation (required)  
Mentor Email Address (required)

Secondary Mentor:

A secondary mentor is not required.

Secondary Mentor First Name (optional)  
Secondary Mentor Last Name (optional)  
Secondary Mentor Institutional Affiliation (optional)  
Secondary Mentor Email Address (optional)

### **Project Proposal**

Curriculum Vitae (PDF format only)

Personal Statement

(Describe your previous involvement with relevant coursework, clinical work, research, program or policy development and indicate your future career plans as they relate to your selected Pathway.)

(250 words maximum)

*(Please include your residency/specialty plans in this section, if known.)*

### **Project Proposal**

Please provide the most detailed overview of your proposed project *possible*.

The Pathways to Discovery Program is a competitive application process.

If you are still in the formative stages with your project, include as much information below as possible in order to distinguish your application. If accepted, you will be given the resources and time to update your project and mentor information at a later date.

**NOTE: If you do not have a clear project proposal in mind yet, please enter TBA into the fields you wish to leave blank.**

Project Title (required)

Project Aims  
(Please list)  
(required)

Background and Significance\*

(Rationale for your project and significance to the literature)

(required)

Project Design and Methods

(Describe your project proposal, including its design, setting, participants, and specific procedures. Explain your plan for development and implementation to the best of your ability. NOTE: You will have the opportunity to change and refine your project as needed during your time with the Pathway, however, this proposal provides the selection committee context in understanding the direction of your work.)

(required)

Scholarly Product(s)

(List of abstracts, presentations, posters, or manuscripts related to proposed project.)

(400 words maximum)

(required)

Project Timeline\*

(required)

**CHR Approval and Project Support**

Do you have CHR approval?\*

Yes

No

If yes,

CHR approval number

(Include your Primary Investigator's approval number if your project scope is within another application)

If no,

Does the project require approval?

Yes

No

Uncertain

If yes,

Timeline for obtaining approval.

If no,

Explain why your project does not require CHR approval.

Do you have IACUC approval?

(Institutional Animal Care and Use Committee)

Yes

No

If yes,

IACUC Approval Number

**Project Funding**

Do you or your mentor have funding to support any portion of this project, e.g. transcriptions, translations, statistical support, software?

Yes

No

If yes,

Please provide details about those funding sources.

COMMENT