

Dear Junior Medical Applicant,

Thank you for your interest in the UCHealth Junior Medical Program. The Junior Medical Program is designed for rising high school juniors, seniors and recently graduated students who are considering a future in healthcare. It provides a realistic picture of healthcare through discussions with healthcare providers, interactions with staff and hands-on experiences in hospital processes. Each session of the 2026 Junior Medical Program will last four days, running Tuesday –Friday, from 8am – 1pm.

2026 Session Dates

- Session 1: Starts June 23.
- Sessions 2–4: Held weekly throughout July.
- *Note: You must rank your top three session preferences on your application.*

Application Details

- Deadline: April 30, 2026 (or until full).
- Selection Process: First-come, first-served, UCHealth employees and current volunteers.
- Cost: \$100 fee (payable upon acceptance).
- Submission: Email your completed application to include letters of recommendation to VolunteerServicesSouthernColorado@uchealth.org

To ensure your application moves forward, please make sure to submit your form, transcripts, and letters of recommendation as a single, comprehensive package! We are unable to process individual documents or incomplete files, so having everything in one package is the best way to get started.

If you are accepted to the program you will receive an email indicating your acceptance, link to complete the fee process and next steps.

Personal Information of Applicant:

Name: _____

Address: _____

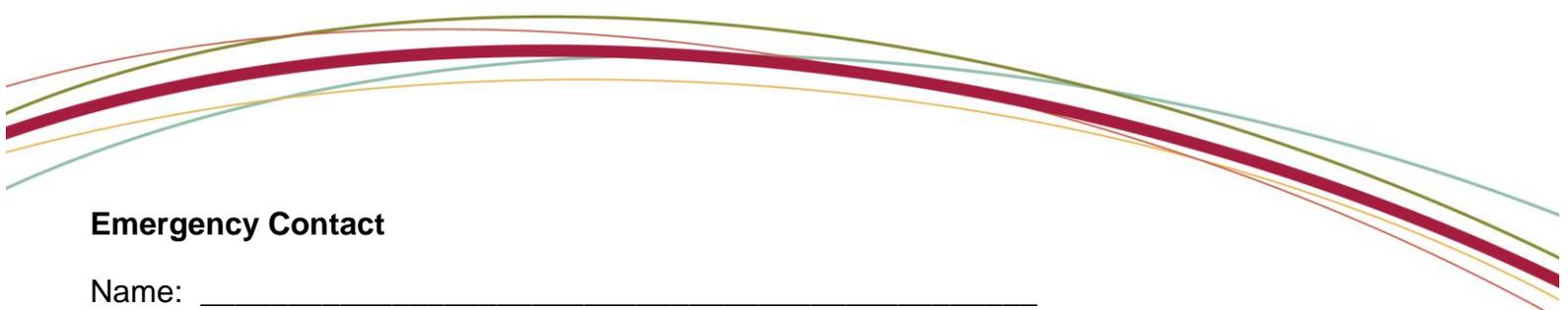
Date of birth: ____/____/____

Email: _____

Phone number: _____

Name of High School: _____

Grade level/graduation date: _____ GPA: _____



Emergency Contact

Name: _____

Address: _____

Phone number: _____

Relationship to Applicant: _____

UCHealth Employee

Are you an immediate family member of an UCHealth employee?

Name of employee: _____

Site where they are employed: _____

Role of employee: _____

Relationship to applicant: _____

Are you a current volunteer at UCHealth? Yes _____ No _____

Can you show proof of vaccination/evidence of immunity for Varicella (chicken pox), tDap (tetanus, diphtheria, and pertussis), MMR (measles, mumps, rubella) and TB (tuberculosis)?

Yes _____ No _____

Please indicate with a 1, 2, 3 and 4, in order of preference for the Junior Medical Program sessions:

- | | | | | |
|-------------------------------------|---|---|---|---|
| <input type="checkbox"/> June 23-26 | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> July 7-10 | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> July 14-17 | 1 | 2 | 3 | 4 |
| <input type="checkbox"/> July 21-24 | 1 | 2 | 3 | 4 |

Why do you wish to attend the Junior Medical Program?

List any other activities/programs/adventures you are participating in this summer:



Release Authorization

- **Consent and Liability release form**

I hereby consent to participate in the UCHealth Junior Medical Program. I understand the purpose of this opportunity is to gain experience by interacting with healthcare professionals at Memorial in their day-to-day work and classroom environments to further my interest in a healthcare career.

- **Risks**

I understand that I will be working with hospital professionals as they respond to requests for medical care and services. I further understand that in responding to such requests, I may be exposed to conditions and situations that may be dangerous and traumatic. Such conditions and situations include, but are not limited to, exposure to hazardous materials/chemicals exposure to communicable diseases, airborne pathogens, and risk of physical harm. I also acknowledge that I may be exposed to risks that cannot be anticipated. I further understand that the hospital professionals' obligations are to render care and treatment to patients first and therefore the hospital professional may not be able to protect me from the various risks to which I may be exposed.

- **Release**

I acknowledge that there are risks involved in my participation in the program as listed above and hereby agree to hold harmless and forever UCHealth and its trustees, officers, directors, employees representatives, and agents from any and all actions, claims, demands or damages that I, my assignees, heirs, guardians, next-of-kin, spouse and legal representatives now have, or may have in the future related to any illness or loss that I may experience including any physical or emotional injury as a result of my participation. I acknowledge and approve the opportunity for a blood draw to learn my blood type as part of the lab portion of the program and allow that process to be completed. I acknowledge I will be shown basic medical suturing techniques and given opportunity to practice these demonstrations.

- **Confidentiality**

I further acknowledge that in the course of this experience, I may become aware of facts relating to patient identity and private healthcare information, such as diagnosis, treatment, complaints, or financial information. I fully understand that all patient health information (PHI) identity and all the facts relating to the care and treatment rendered by the UCHealth professionals are strictly confidential, both ethically and legally. I understand that no time can any such information be discussed even after I complete my participation in the program. I understand that I am expected to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as other applicable laws and internal policies of UCHealth.



Release Authorization

- **Immunization status**

I or my legal guardian represent that my immunizations are current and up to date. I agree to have my immunization status reviewed by UCHHealth Employee Health and to receive any immunizations required for participation including but not limited to Varicella, TDAP and MMR.

- **Application rules**

Only fully complete applications will be considered. I understand that if accepted into the program, I will be on time and attend all days of programming. I will conduct myself in an appropriate manner as defined by UCHHealth practices and policies. Any dispute regarding the acceptance of applicants is at the discretion of UCHHealth Memorial Volunteer Services department.

- **Signature Requirements**

All applicants under the age of 18, must have a parent/legal guardian signature/consent.

Signature _____

Date _____

Legal Guardian Signature (if under 18) _____

Date _____