



APPLICANT

Full Legal Name: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Contact Address: \_\_\_\_\_  
AMCAS ID Number: \_\_\_\_\_

ACADEMICS

Degree Granting Undergraduate College/University: \_\_\_\_\_ Cumulative GPA: \_\_\_\_\_

Augusta University

Cumulative GPA: \_\_\_\_\_

Matriculation Year to AU: \_\_\_\_\_

Medical College Aptitude Test (MCAT)

*\* Please indicate numeric score as well as percentage \**

Critical Analysis/Reasoning:

Chemical/Physical Foundations:

Biological/Biochemical Foundations:

Psychological/Social Foundations:

Total MCAT Score: \_\_\_\_\_

ADDITIONAL REQUIREMENTS

1. Please attach abstracts and published articles you have authored or co-authored.
2. Please attach a copy of your unofficial AU transcript.
3. On a separate page, describe your desire to enter the dual degree MD/PhD program and your research interests.
4. On a separate page, describe all of your substantial research experience(s).
5. The MD/PhD admissions committee would be particularly interested in letters of recommendation from research mentors. Request two letters of recommendation from individuals who are in a position to critically assess your research potential. Please provide their names and information below.

Name	Department/Position	Institution	Date requested
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Name	Department/Position	Institution	Date requested
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SIGNATURE

In signing this form, I declare that the above information is true, correct and complete. I also waive my right of access to my letters of recommendation and release to the MD/PhD Admissions Committee information contained in my application for admission to Augusta University and the Medical College of Georgia.

Signature	Date
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Return completed application form and letters of recommendation to:

Patricia Frederickson, MD/PhD Program Manager  
Augusta University, GB-3350H  
Augusta, Georgia 30912

mdphd@augusta.edu  
Phone: 706-721-7835