

*Scholarship Application*

**ALLEGHENY COUNTY MEDICAL SOCIETY (ACMS) MEDICAL STUDENT SCHOLARSHIP**

*A \$2,000 scholarship will be awarded to two qualified medical students.*

**Instructions:**

- Complete application by typing or printing clearly using a dark ink.
- Understand that "you" and "your" on this form indicates the student who is applying for the scholarship.
- Application materials must be postmarked by September 30 of the current year. Forward the following materials to The Foundation of the Pennsylvania Medical Society:
  1. Scholarship application
  2. Two reference letters (at least one letter must be from a medical school professor or a physician)
  3. Verification letter from your medical school
  4. Essay: Where do you see yourself in 10 years? How do you plan to give back to the community?

Your title:  Mr.  Miss  Mrs.  Ms.

Your name: 

<i>First name</i>	<i>M.I.</i>	<i>Last name</i>

Your social security number: 

— —	E-mail: <input style="width: 90%;" type="text"/>
-----	--

Your mailing address: *(All mail will be sent to this address.)*  

<i>Number and street (include apartment number)</i>		
---	--	--

<i>City</i>	<i>State</i>	<i>ZIP code</i>

Mailing address telephone #: 

(     )	—
---------	---

Your legal/permanent address: *(If different from above address.)*  

<i>Number and street (include apartment number)</i>		
---	--	--

<i>City</i>	<i>State</i>	<i>ZIP code</i>

Legal/permanent address telephone #: 

(     )	—
---------	---

Date of birth: 

<i>Month</i>	<i>Day</i>	<i>Year (optional)</i>
/	/	

Are you a U.S. Citizen?  Yes  No

County of residence: 

--

Date you became a PA resident? 

<i>Month</i>	<i>Year</i>
/	

ACMS MEDICAL STUDENT SCHOLARSHIP APPLICATION

Page 2

PERSONAL INFORMATION CONTINUED

Marital status *[optional]*:    Single    Married    Separated    Divorced    Widowed

Number of children/dependents? (other than spouse)       Number of dependent children in college?

Are you or your spouse Pennsylvania Medical Society member(s)?    Self    Spouse    Neither

Are you or your spouse an Allegheny County Medical Society member(s)?    Self    Spouse    Neither

COMMUNITY INVOLVEMENT

*If needed, an additional sheet of paper may be used to answer and comment on the following:*

Explain to whom and how you have rendered Community Service.

List and explain leadership positions you have held (during and prior to medical school).

How do you see yourself working in organized medicine?

MISCELLANEOUS COMMENTS

This space is provided for you to inform the Foundation of any special circumstance(s) or condition(s). *[optional]*

ACMS MEDICAL STUDENT SCHOLARSHIP APPLICATION

PARENTAL INFORMATION

Your parent(s) name and address:

Name of your parent(s)

--

Address

--

City

State

ZIP code

--	--	--

Parent(s) telephone #:

( )		-	
-----	--	---	--

Relationship to you?:  
(i.e., parents, mother, father, etc.)

--

Number of college students in parent(s) household in 2008-2009?

--

Are parent(s) Pennsylvania Medical Society member(s)?

yes

no

EDUCATIONAL BACKGROUND

High school attended:

Name

--

City

State

--	--

Time period attended (mo. & yr.)

Course taken/degree earned

Did you graduate?

	n/a	<input type="checkbox"/> yes <input type="checkbox"/> no
--	-----	--

College attended:

Name

--

City

State

--	--

Time period attended (mo. & yr.)

Course taken/degree earned

Did you graduate?

		<input type="checkbox"/> yes <input type="checkbox"/> no
--	--	--

Other school attended:

Name

--

City

State

--	--

Time period attended (mo. & yr.)

Course taken/degree earned

Did you graduate?

		<input type="checkbox"/> yes <input type="checkbox"/> no
--	--	--

If education was interrupted because of illness, military service, employment, etc. please explain giving dates and circumstances.

--

ACMS MEDICAL STUDENT SCHOLARSHIP APPLICATION

Page 4

MEDICAL SCHOOL INFORMATION

Medical school name:

Medical school address:

*Street Address*

*City*

*State*

*ZIP code*

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

First year/freshman  
start date:

*Month*

*Year*

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Graduation/  
end date:

*Month*

*Year*

<input type="text"/>	<input type="text"/>
----------------------	----------------------

*I certify that the application materials being submitted are, to the best of my knowledge and belief, complete and correct. I grant the Foundation the authority to verify any of the information on this application. I authorize my medical school to release my grades and all other data requested to meet the scholarship's requirements and guidelines.*

*Date*

*Applicant's signature*

<input type="text"/>	<input type="text"/>
----------------------	----------------------

All applicants will be notified in December of the current year.

**Please forward all application materials to:**

**ACMS Scholarship**  
c/o The Foundation  
777 East Park Drive  
P.O. Box 8820  
Harrisburg, PA 17105-8820

**TELEPHONE:** (800) 228-7823, Ext. 7852 *[in PA only]* or (717) 558-7854

**FAX:** (717) 558-7818

**E-MAIL:** studentservices-foundation@pamedsoc.org

**WEB:** www.foundationpamedsoc.org

**Application materials must be postmarked by September 30 of the current year.**

*This medical scholarship is made possible by contributions  
from Allegheny County Medical Society Foundation.*