



The Foundation of the Pennsylvania Medical Society

APPLICATION

**SCOTT A. GUNDER, MD, DCMS
PRESIDENTIAL SCHOLARSHIP FUND**

A \$1,500 scholarship is awarded to a second-year medical student at Penn State College of Medicine.

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 April 15 of the current year. Forward the following to The Foundation of the Pennsylvania Medical Society:
 1. Scholarship application
 2. Two reference letters
 3. Verification letter from Penn State College of Medicine
 4. Essay describing the person or event that most influenced you to become a physician and how you see yourself leading others into medicine.
 5. Pennsylvania Medical Society membership application, if needed

Your title:

Mr. Miss, Mrs., or Ms.

Your name:

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

Your social security number:

-	-	E-mail:

Your mailing address:

(All mail will be sent to this address)

Number and street (include apartment number)

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

Mailing address telephone #:

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Your legal/permanent address:

(If different from above address)

Number and street (include apartment number)

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

Legal/permanent address telephone #:

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Date of birth:

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

Are you a PA resident?

Yes No

County of Legal Residence:

Date you became a PA resident?

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

SCOTT A. GUNDER, MD
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Application ♦ Side 2

Undergraduate school name:			
Undergraduate school address:	<small>City</small>	<small>State</small>	
Undergraduate degree/curriculum:			
Undergraduate graduation date:	<small>Month</small>	<small>Year</small>	

Medical school name:	Penn State College of Medicine				
Medical school address:	<small>City</small>	<small>State</small>			
First year/freshman start date:	<small>Month</small>	<small>Year</small>	Graduation/ end date:	<small>Month</small>	<small>Year</small>

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 and authorize Penn State College of Medicine to release my grades and all other data requested to meet its requirements and guidelines.

<small>Date</small>	<small>Applicant's signature</small>
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All applicants will be notified in June of the current year.

Please forward all application materials to:

Scott A. Gunder, MD, DCMS Presidential Scholarship Fund
c/o The Foundation
777 East Park Drive, P.O. Box 8820
Harrisburg, PA 17105-8820

TEL: (717) 558-7854 ♦ FAX: (717) 558-7818
E-MAIL: studentservices-foundation@pamedsoc.org
WEB: www.foundationpamedsoc.org

Application materials must be postmarked by April 15 of the current year.

This medical scholarship was established by the Dauphin County Medical Society in memory of its past president, Scott A. Gunder, MD.

Please Note

As of January 1, 2008, students applying for the Scott A. Gunder, MD, DCMS Presidential Scholarship must be or become a member of the Pennsylvania Medical Society and county medical society. **Student membership is free.** If you are not a current Pennsylvania Medical Society member, please complete this application and return along with the completed Scott A. Gunder, MD, DCMS Presidential Scholarship application materials. Thank you.

Student Membership Application



Pennsylvania
MEDICAL SOCIETY®

_____ County Medical Society
(Please indicate the county in which you work or live)

Office Code:

777 East Park Drive, PO Box 8820, Harrisburg, PA 17105-8820 * 717-558-7750 (Phone) * 717-558-7840 (Fax)

FULL NAME (PRINT): _____
Last First Middle

HOME: _____
Area Code & Phone Number

OFFICE: _____
Area Code & Phone Number

Email Address _____ Office Fax _____

For mailing, please use: office address _____ home address _____

BIOGRAPHICAL DATA Sex _____ SPOUSE'S NAME _____
Birth Place _____ Date of Birth _____
Government Service: Military__ National Health Service__ Beginning Date _____ Completion Date _____

EDUCATION	INSTITUTION	LOCATION	DEGREE	BEGIN DATE	END DATE
Pre-Med	_____	_____	_____	_____	-
Medical	_____	_____	_____	_____	-

PROFESSIONAL DATA

Previous Medical Society Memberships (List Dates): _____

Specialty Society Memberships _____

Within the last 5 years, have you been convicted of a felony crime? Yes No. If yes, please provide full information.

Within the last 5 years, has your license to practice medicine in any jurisdiction been limited suspended or revoked? Yes No. If yes, please provide full information.

Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff? Yes No. If yes, please provide full information.

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the County Medical Society, the Pennsylvania Medical Society and the American Medical Association.

I hereby release, and hold harmless from any liability or loss, the County Medical Society, the Pennsylvania Medical Society, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I also authorize the above named organizations, in the consideration of my application, to make inquiry of any of my references and institutions by whom I have been employed or extended privileges, as to my qualifications. I further authorize any of the above persons or institutions to forward any and all information their records may contain, and agree to hold them harmless for any action by me for their acts.

DATE _____

SIGNATURE _____