The Foundation
of the Pennsylvania Medical Society

Lycoming County Medical Society

Application for the

LYCOMING COUNTY MEDICAL SOCIETY SCHOLARSHIP
2010-2011 ACADEMIC YEAR AWARD

Two qualified medical students will each be awarded a $2,000 scholarship.

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**
  3. **Verification letter from your medical school**
  4. **Essay: Typed one-page essay addressing why you chose to become a physician and what contributions you expect to make to the health profession.**

Your title: ❑ Mr. ❑ Miss, Mrs., Ms.

Your name: *First name* ______ *M.I.* ______ *Last name* ______

Your social security number: ____ – ____ – ____ E-mail: ______

Your mailing address: *Number and street (include apartment number)* ______
(All mail will be sent to this address.)

City ______ *State* ______ *ZIP code* ______

Mailing address telephone #: (   ) ____ – ____

Your legal/permanent address: *Number and street (include apartment number)* ______
(If different from above address.)

City ______ *State* ______ *ZIP code* ______

Legal/permanent address telephone #: (   ) ____ – ____

Date of birth: *Month* ____ / *Day* ____ / *Year (optional)* ____

Are you a PA resident? ❑ Yes ❑ No

County of legal/permanent address: ______

Date you became a PA resident? *Month* ____ *Year* ____

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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 a Lycoming County Medical Society member(s)? ❐ Self ❐ Spouse ❐ Neither

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?

Are parent(s) Pennsylvania Medical Society member(s)? ❐ yes ❐ no

COMMUNITY INVOLVEMENT & ACHIEVEMENTS

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).

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Community Involvement & Achievements Continued

List any academic awards and recognitions that you have received.

Future Expectations

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

Where do you see yourself in 10 years?

Miscellaneous Comments

This space is provided for you to note any special circumstance(s) or condition(s) that you would like considered (i.e., employment, military service, illness, interrupted education, etc.).

Educational Background

High school attended:

Name		
City		*State*
Time period attended (mo. & yr.)	*Course taken/degree earned*	*Did you graduate?*
	n/a	❒ yes ❒ no

College attended:

Name		
City		*State*
Time period attended (mo. & yr.)	*Course taken/degree earned*	*Did you graduate?*
		❒ yes ❒ no

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EDUCATIONAL BACKGROUND CONTINUED

Other school attended:

Name

City | *State*

Time period attended (mo. & yr.) | *Course taken/degree earned* | *Did you graduate?* ❐ yes ❐ no

MEDICAL SCHOOL INFORMATION

Medical school name:

Medical school address:

Street Address

City | *State* | *ZIP code*

First year/freshman start date: *Month* | *Year*

Graduation/ end date: *Month* | *Year*

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***

Application materials must be postmarked by September 30 of the current year and forwarded to:

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

Telephone: (717) 558-7854
FAX: (717) 558-7818
E-Mail: studentservices-foundation@pamedsoc.org
WEB: www.foundationpamedsoc.org

This medical scholarship is made possible by contributions from Lycoming County physicians.