

*Scholarship Application*

**LECOMASE MEDICAL STUDENT SCHOLARSHIP**

*A \$2,500 scholarship will be awarded to a qualified medical student.*

**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: Typed one-page essay addressing your goals and expectations in medicine?

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"/>
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Your mailing address:

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

*Number and street (include apartment number)*

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<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)*

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<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 U.S. Citizen?    Yes    No

County of legal/permanent address:  

Date you became a PA resident?   

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

LECOMASE MEDICAL STUDENT SCHOLARSHIP APPLICATION

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PERSONAL INFORMATION CONTINUED

Marital status     Single     Married     Separated     Divorced     Widowed

Spouse's Name?                       Spouse's Occupation?

Number of dependent children?     List Ages     Number of dependent children in college?

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 (high school to present).

List and explain leadership positions you have held from high school to present.

List any academic awards and recognitions that you have received.

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.).

**LECOMASE MEDICAL STUDENT SCHOLARSHIP APPLICATION**

**PARENTAL INFORMATION**

Your parent(s) name and address:

*Name of your parent(s)*

*Address*

*City*

*State*

*ZIP code*

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Parent(s) telephone #:

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

Number of siblings in parents household who are college students for the upcoming academic year?

**EDUCATIONAL INDEBTEDNESS AND SOURCES OF INCOME**

Do you have undergraduate school debt?

yes     no

Do you have graduate school debt?

yes     no

Do you have medical school debt?

yes     no

Do you have other debt (auto, credit cards, personal, etc.)?

yes     no

Approximate total of all educational indebtedness:

\$

Have you applied for other scholarships and/or grants for the upcoming academic year?

yes     no

Do you know if you will receive any scholarships and/or grants for the upcoming academic year?

yes     no

Will you receive financial assistance from your parents, other relatives, or friends during the upcoming academic year?

yes     no

Will you receive any untaxed income and/or benefits (i.e., child support, social security benefits, workers compensation, welfare, etc.) during the upcoming academic year?

yes     no

Will you receive any other source of income not identified above for the upcoming academic year?

yes     no

Approximate total of all sources of income to be used for the upcoming academic year:

\$

**EDUCATIONAL BACKGROUND**

High school attended:

*Name*

*City*

*State*

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*Time period attended (mo. & yr.)*

*Course taken/degree earned*

*Did you graduate?*

n/a		<input type="checkbox"/> yes <input type="checkbox"/> no
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College attended:

*Name*

*City*

*State*

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*Time period attended (mo. & yr.)*

*Course taken/degree earned*

*Did you graduate?*

		<input type="checkbox"/> yes <input type="checkbox"/> no
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**LECOMASE MEDICAL STUDENT SCHOLARSHIP APPLICATION**

**EDUCATIONAL BACKGROUND CONTINUED**

Other school attended:

yes  no

**MEDICAL SCHOOL INFORMATION**

Medical school name:

Medical school address:

First year/freshman start date:

Graduation/end date:

*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:**

**LeCoMASE 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](mailto:studentservices-foundation@pamedsoc.org)

**WEB:** [www.foundationpamedsoc.org](http://www.foundationpamedsoc.org)

*This medical scholarship is made possible by contributions from the Lehigh County Medical Auxiliary's Scholarship and Educational Fund (LeCoMASE).*