



The Foundation
of the Pennsylvania Medical Society



Scholarship Application

MONTGOMERY COUNTY MEDICAL SOCIETY (MCMS) SCHOLARSHIP

A \$1,000 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
 3. Verification letter from your medical school
 4. Essay addressing the following: Reasons for pursuing a medical career, personal goals, and plans for future within the profession.

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: <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)

<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 U.S. Citizen? Yes No

County of legal residence:

Date you became a PA resident?

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

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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 a Pennsylvania Medical Society member? * Yes No*

Are you a Montgomery County Medical Society member? * Yes No*

*Scholarship recipient(s) will be required to complete a membership application (No Cost).

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?

EDUCATIONAL BACKGROUND

High school:

Name

City

State

Time period attended (mo. & yr.)

Course taken/degree earned

Did you graduate?

<input type="text"/>	n/a	<input type="checkbox"/> yes <input type="checkbox"/> no
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Undergraduate School:

Name

City

State

Undergraduate graduation date

Undergraduate degree/curriculum

Did you graduate?

<input type="text"/>	<input type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
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If education was interrupted because of illness, military service, employment, etc. please explain giving dates and circumstances.

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MEDICAL SCHOOL INFORMATION

Medical school name:

Medical school address:

Street Address

City

State

ZIP code

<input type="text"/>	<input type="text"/>	<input type="text"/>
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First year/freshman
start date:

Month

Year

<input type="text"/>	<input type="text"/>
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Graduation/
end date:

Month

Year

<input type="text"/>	<input type="text"/>
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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"/>
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Application materials must be postmarked by September 30 of the current year.

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

Please forward all application materials to:

MCMS 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 Montgomery County Medical Society and physicians.