



ALLEGHENY COUNTY MEDICAL SOCIETY MEDICAL STUDENT SCHOLARSHIP

A \$4,000 scholarship will be awarded to a qualified medical student.

Eligibility for scholarship applicants:

- Applicant must be a United States citizen.
- Applicant must be a resident of Allegheny County in the state of Pennsylvania for at least 12 months prior to registering as a medical student (not including time spent attending an undergraduate/graduate school in Pennsylvania).
- Applicant must be enrolled full time in a fully accredited Pennsylvania medical school.
- Applicant must be enrolled in or entering his/her third or fourth year of medical school.
- Applicant cannot be a past recipient of the Allegheny County Medical Society Medical Student Scholarship.

Applicant must submit:

- 1. A completed scholarship application form.
- 2. Two reference letters, from persons other than family members, documenting the applicant's integrity, interpersonal skills, and potential as a future physician. *Note: One reference letter must be from either a medical school professor or a physician.*
- 3. A letter, on school letterhead, from the applicant's medical school verifying that he/she is enrolled full time as a third- or fourth-year medical student at that institution.
- 4. **A typed one-page essay addressing the following:** How do you hope to be involved in your community beyond clinical care of patients? In what ways would you hope to demonstrate leadership as a physician in your community?

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

Applicants will be notified of the committee's decision in December of the current year.

Application materials should be mailed to:

Allegheny CMS Scholarship

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

TEL: (717) 558-7846 or (717) 558-7854 ◆ **FAX:** (717) 558-7818 **E-MAIL:** studentservices-foundation@pamedsoc.org **WEB:** www.foundationpamedsoc.org

This Page Has Been Intentionally Left Blank





ALLEGHENY COUNTY MEDICAL SOCIETY MEDICAL STUDENT SCHOLARSHIP

A \$4,000 scholarship will be awarded to a qualified medical student.

Instructions:

- Complete application by typing into this form or print the form and complete 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 (must be signed by hand)
 - 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: How do you hope to be involved in your community beyond clinical care of patients? In what ways would you hope to demonstrate leadership as a physician in your community?

Your title:		Mr.	Miss, Mrs., or Ms.						
Your name:		First name		M.I.	Last name				
Your social security number:				E-mail:	:				
Your mailing address: (All mail will be sent to this address.)	Number and street	t (include apartment numb	per)					
	,	City			State	?	ZIP code		
Mailing address telephone #					Is t	his a ce	ell phone?	Yes	No
Your legal/permanent address: (If different from above address.)		Number and stree	et (include apartment numl	ber)					
ij aijerem from above adaress.)		City			State	2	ZIP code		
Legal/permanent address telepho	one #:				Is th	nis a ce	ll phone?	Yes	No
Are you a U.S. Citizen?	Yes	No	Date of birth:	Month	/Day/Year (for	mat mm	/dd/yyyy)		
Are you a PA Resident?	Yes	No	Date you becan	me a PA	resident:	Month	/Year (format 1	nm/yyyy)	
Driver's License State:			Driver's Licen	se Num	ber:				
Are you a resident of Allegheny County?	Yes	No	Date you becan Allegheny Cou		sident of	Мо	nth/Year (form	aat mm/yyyy)	

ALLEGHENY CMS 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 are very self-weaking in angering day dising 9
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]

ALLEGHENY CMS SCHOLARSHIP APPLICATION

Page 3

PARENTAL INFORMATION

Your parent(s) name and address:	Name of your parent(s)							
	Number and Street (include apartment number)							
	City	State	ZIP code					
	Parent(s) telephone #:	Is this a c	ell phone?	Yes	No			
	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)? Y	es No	•				

EDUCATIONAL BACKGROUND

High School:	Name					
	City		State			
	Time period attended (format mm/yyyy - mm/yyyy)	Course taken/degree earned	Did :	you graduate? Yes	No	
Undergraduate School:	Name					
Ondergraduate Benoon.	City		State			
	Time period attended (format mm/yyyy - mm/yyyy)	Course taken/degree earned		Did you graduat Yes		No
Other School Attended:	Name					
Other School Attended.	City		State			
	Time period attended (format mm/yyyy - mm/yyyy)	Course taken/degree earned		Did you graduat	e?	No

If education was interrupted because of illness, military service, employment, etc., please explain giving dates and circumstances. *If needed, an additional sheet of paper may be used to comment.*

ALLEGHENY CMS SCHOLARSHIP APPLICATION

Page 4

MEDICAL SCHOOL INFORMATION				
Medical school name:				
Medical school address:	Number and Street (include building, suite, and/or room	number)		
	City		State	ZIP code
First year/freshman start date:	Month/Year (format mm/yyyy)	Graduation/ end date:	Month/Year	(format mm/yyyy)

I certify that the application materials being submitted are, to the best of my knowledge and belief, complete and correct. I grant the Foundation of the Pennsylvania Medical Society 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.

By signing this form, I hereby grant the Foundation and the Allegheny County Medical Society and its foundation the unconditional right to use, including but not limited to, my name, photograph (taken or submitted), and essay in connection with any manner or medium, including but not limited to press releases, publications, and/or websites for distribution in both printed and digital formats.

Date	Applicant's signature	

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

Please forward all application materials to:

Allegheny CMS Scholarship

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

TELEPHONE: (717) 558-7846 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 student scholarship is made possible by contributions from Allegheny County Medical Society Foundation.