



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

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ALLEGHENY CMS SCHOLARSHIP APPLICATION

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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 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 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

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 cell 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)?

Yes

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

City

State

Time period attended (format mm/yyyy - mm/yyyy)

Course taken/degree earned

Did you graduate?

Yes

No

Other School Attended:

Name

City

State

Time period attended (format mm/yyyy - mm/yyyy)

Course taken/degree earned

Did you graduate?

Yes

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.

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MEDICAL SCHOOL INFORMATION

Medical school name:

Number and Street (include building, suite, and/or room number)

Medical school address:

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

Form fields for Date and Applicant's signature

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

Please forward all application materials to:

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This medical student scholarship is made possible by contributions from Allegheny County Medical Society Foundation.