The Foundation
of the Pennsylvania Medical Society
Education. Wellness. Excellence. *Always.*

LYCOMING COUNTY MEDICAL SOCIETY SCHOLARSHIP
2018-2019 ACADEMIC YEAR AWARD

Three scholarships in the amount of $3,000 each will be awarded.

Eligibility for scholarship applicants includes the following:

- Applicant must be a United States citizen.
- Applicant must be a resident of Lycoming 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 allopathic or osteopathic medical school within the United States.
- Applicant cannot be a recipient of the Lycoming County Medical Society Scholarship in the immediate prior year of this application.

Applicant must submit the following:

1. A completed 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.
3. A letter, on school letterhead, from the applicant's medical school verifying that he/she is enrolled full time as a medical student at their institution.
4. A typed one-page essay specifically describing **why the applicant chose to become a physician and what contributions he/she expects to make to the health profession.**

A PERSONAL INTERVIEW IS NOT REQUIRED; HOWEVER, IT MAY BE REQUESTED.

Application materials must be postmarked by <u>September 30</u> 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:
Lycoming 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 medical scholarship is made possible by contributions from Lycoming County physicians.

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LYCOMING COUNTY MEDICAL SOCIETY SCHOLARSHIP

2018-2019 ACADEMIC YEAR AWARD

Three $3,000 scholarships will be awarded to qualified medical students.

Instructions:

- **Complete application by typing into this form and printing 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**
  3. **Verification letter from your medical school**
  4. **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:
(All mail will be sent to this address.)
Number and street (include apartment number) _____
City _____ *State* _____ *ZIP code* _____

Mailing address telephone #: _____ Is this a cell phone? ☐ Yes ☐ No

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Your legal/permanent address:
(If different from address above.)
Number and street (include apartment number) _____
City _____ *State* _____ *ZIP code* _____

Legal/permanent address telephone#: _____ Is this a cell phone? ☐ Yes ☐ No

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Are you a U.S. Citizen? ☐ Yes ☐ No

Date of birth: *Month/Day/Year (format mm/dd/yyyy)* _____

Are you a PA Resident? ☐ Yes ☐ No

Date you became a PA resident: *Month/Year (format mm/yyyy)* _____

Driver's License State: _____

Driver's License Number: _____

Are you a resident of Lycoming County? ☐ Yes ☐ No

Date you became a resident of Lycoming County: *Month/Year (format mm/yyyy)* _____

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

PARENTAL INFORMATION

Your parent(s) name and address:

Name of your parent(s)

Number and street (include apartment numnber

City *State* *ZIP code*

Parent(s) telephone #: Is this a cell phone? ☐ Yes ☐ No

Relationship to you:
(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).

LYCOMING CMS SCHOLARSHIP APPLICATION

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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? Where and how do you plan to practice medicine?

MISCELLANEOUS COMMENTS

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

EDUCATIONAL BACKGROUND

High school attended:

Name

City *State*

Time period attended (format mm/yyyy - mm/yyyy) *Course taken/degree earned* *Did you graduate?*

N/A ☐ Yes ☐ No

College attended:

Name

City *State*

Time period attended (format mm/yyyy - mm/yyyy) *Course taken/degree earned* *Did you graduate?*

☐ Yes ☐ No

LYCOMING CMS SCHOLARSHIP APPLICATION

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EDUCATIONAL BACKGROUND CONTINUED

Other school attended:

Name

City

State

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

Course taken/degree earned

Did you graduate? ☐ Yes ☐ No

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 Lycoming County Medical Society 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***

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

PRINT APPLICATION

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

CLEAR FORM DATA

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