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

MCMS
MONTGOMERY COUNTY
MEDICAL SOCIETY

MONTGOMERY COUNTY MEDICAL SOCIETY
WILLIAM W. LANDER, MD, MEDICAL STUDENT SCHOLARSHIP

2018-2019 ACADEMIC YEAR AWARD

Two scholarships in the amount of $2,000 each will be awarded.

Eligibility for scholarship applicants:

- Applicant must be a United States citizen.
- Applicant must be a resident of Montgomery County in the state of Pennsylvania at the time of high school graduation or for at least 4 years prior to registering as a medical student.
- Applicant must be enrolled full time in a fully accredited United States medical school.
- Applicant must be enrolled in or entering his/her first year of medical school.

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 physician.
3. A letter, on school letterhead, from the applicant's medical school verifying that he/she is enrolled full time as a first-year medical student at that institution.
4. **A typed one-page essay addressing the following:** *Reasons for pursuing a medical career, personal goals, and plans for future within the profession.*

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:

Montgomery CMS—Lander 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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Two scholarships in the amount of $2,000 each will be awarded.

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. **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: *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 above address.)
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 Montgomery County? ☐ Yes ☐ No

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

MONTGOMERY CMS—LANDER 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 a Pennsylvania Medical Society member?* ☐ Yes ☐ No*

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

**Scholarship recipient will be required to complete a membership application (no cost).*

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 (parents, mother, father, etc.): _____

Number of college students in parent(s) household: _____

EDUCATIONAL BACKGROUND

High school:

Name

City *State*

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

N/A ☐ Yes ☐ No

Undergraduate School:

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)*

COMMUNITY INVOLVEMENT AND 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 (high school to present).

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

List any academic awards and recognition that you have received (high school to present).

FUTURE EXPECTATIONS WITHIN THE COMMUNITY OF ORGANIZED MEDICINE

Physician membership organizations at the state level, like the Pennsylvania Medical Society, and at the national level, like the American Medical Association, help doctors take care of patients. These organizations are sometimes collectively referred to as organized medicine. They promote physician leadership at all stages of one's career. Do you see yourself fitting into organized medicine or do you see a different role for yourself within the practice of medicine? Please elaborate. *If needed, an additional sheet of paper may be used to comment.*

SPECIAL CIRCUMSTANCES(S) AND/OR CONDITION(S)

This space is provided for you to note any special circumstance(s) or condition(s) that you would like to have considered (i.e., employment, military service, illness, interrupted education, family situations/hardships, etc.). *If needed, an additional sheet of paper may be used to comment.*

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 Montgomery 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.

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

Please forward all application materials to:

PRINT APPLICATION

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This medical scholarship is made possible by contributions from Montgomery County Medical Society and physicians.