Scholarship/Award Program Application Form

(Please type or neatly print in black ink)

Please check the scholarship or award you are applying for: **Academic Year: _2007-2008 ___**

- ☐ **The Need Based Scholarship Program**
- ☐ **Mary Ball Carrera Scholarships**
- ☐ **Aura Irving Severinghaus Award**
- ☐ **Ralph Ellison Memorial Prize**
- ☐ **William and Charlotte Cadbury/Franklin C. McLean Award**
- ☐ **Metropolitan Life Foundation Awards Program**
- ☐ **Irving Graef Memorial Scholarship**
- ☐ **Zimmer Scholarship Program**

National Medical Association Special Awards

- ☐ **The Patti LaBelle Scholarship/The NMA Emerging Awards Program**
- ☐ **NMA Awards for Medical Journalism**

Name: ____ **S.S. #** ______-_____-______
(Last) (First) (MI)

Current Address: ____ **Tel#:**____________________
(Number, Street, Apt#)

____
(City, State, Zip Code)

Permanent Address: ____ **Tel**
2#:____________________
(Number, Street, Apt#)

____
(City, State, Zip Code)

E-Mail Address: ____ **Required. NMF will correspond with Applicants via E-mail.**

Date of Birth: _______/_______/_______ **Gender:** ☐ Female ☐ Male

Marital Status: Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married ☐

Are you a U.S Citizen: ☐ Yes ☐ No **Place of Birth:** ____
(City, State, County)

If a naturalized citizen please provides your certificate number along with proof citizenship: ____________________

☐ **African American** ☐ **Mainland Puerto Rican** ☐ **Mexican American** ☐ **Alaska Native**
☐ **Native Hawaiian** ☐ **Native American** ☐ **Other:** ____________________

Medical School Information:

Name of Medical School:
Address:
Expected Date of receipt of M.D. or D.O. Degree:

Applicant Name:

Education:

	Name	City & State	Dates Attended	Major	Degree	Degree rec'd (date)
High School						
Undergraduate						
Graduate						
Other						

Please list all research projects in which you have participated. Include the year in which the research was done. (Use additional sheets if necessary)

Please list academic honors, prizes or scholarships received in college. (Use additional sheets if necessary)

Please list extracurricular activities and community involvement. Include offices held. (Use additional sheets if necessary)

Employment Experience:

Name of Employer	Address	Position	Dates of Employment

Applicant Name: ______________________________

Parental Information:

Father's Name: ______________________________
(First, MI, Last)

Address: ______________________________

____

Telephone: ______________________________

Birthplace: ______________________________

Occupation: ______________________________

Employer: ______________________________

Level of Education: ______________________________

Annual Gross Income: ______________________________

Mother's Name: ______________________________
(First, MI, Last)

Address: ______________________________

____

Telephone: ______________________________

Birthplace: ______________________________

Occupation: ______________________________

Employer: ______________________________

Level of Education: ______________________________

Annual Gross Income: ______________________________

Parent's Marital Status: Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married ☐

List below names and ages of all siblings.
Use separate sheet (if necessary).

Name	Age	Living with family	Name of Current College/School (If attending college full-time, complete sibling verification form)	Grade level
1		Yes No		
2		Yes No		
3		Yes No		
4		Yes No		

Spouse's Name: ______________________________

Occupation: ______________________________

Spouse's Address: ______________________________
(No. and Street) (City) (State) (Zip)

Spouse Employer: ______________________________
(Name) (City & State)

Gross Annual Income $ ______________

Please list all Dependents:

Name:	Age:	Relation:	Currently in college:

Applicant Name:

The following information MUST be provided whether or not you consider yourself independent.

	Previous Year		Current Year	
Have you lived with your parents for more than six weeks?	☐ Yes	☐ No	☐ Yes	☐ No
Did or will your parents claim you as a US income tax exemption?	☐ Yes	☐ No	☐ Yes	☐ No
Did or will you get more than $1,200 worth of support from your parents?	☐ Yes	☐ No	☐ Yes	☐ No

Income and Expense Information

	Parents	Applicant
1. U.S income tax return for this year has or will be filed by	☐ Yes ☐ No	☐ Yes ☐ No
2. This year's adjusted gross income from IRS tax form (if filling)	$________	$
3. This year's income earn from work by (if not filling)	Mother $________	Applicant $________
	Father $________	Spouse $________
4. Other income and benefits		
a. Social Security benefits (parents include the applicant's benefits)	$________	$________
b. Aid to families with dependent children (AFDC or ADC)	$________	$________
c. All other income and benefits (child support, disability, veteran benefits)	$________	$________

DOCUMENTATION FOR ALL TAXABLE AND NON-TAXABLE INCOME MUST BE SUBMITTED WITH THIS APPLICATION
You must submit complete tax returns and W2 forms or verification of means of support for yourself and each parent.

Asset information

(All information MUST be provided: if inapplicable, put "0" or "n/a")

	Parent(s)		Applicant & Spouse	
	Value	Amount owed?	Value	Amount owed?
1. Cash, savings, and checking accounts	$________	$________	$________	$________
2. Home (renters write "0")	$________	$________	$________	$________
3. Other real estate and investments	$________	$________	$________	$________
4. Business and farm	$________	$________	$________	$________

Applicant Name:

Personal Statement

Provide a statement of at least 500 words discussing your personal and professional goals over the next ten years. Emphasize significant persons and/or events that have influenced your decision. Your name, medical School and Social Security number must appear on each page.

I hereby affirm that all the foregoing information is true and accurate I further agree to submit additional documentation to verify the information reported on this form and any supporting material, and understand that deliberate misrepresentation of the facts will void this application. I also understand that this application and all supporting materials will be reviewed by NMF staff, at any point during my tenure in medical school, in consideration of scholarship or special awards for which I may be eligible. I give my permission for this application and supporting documentation to be copied and distributed only for this purpose.

Applicant Signature: ______________________ **Date:** ______________

Original copies of all application material must be sent to:

National Medical Fellowships
5 Hanover Square
New York, NY 10004

VERIFICATION FORM FOR DEPENDENT SIBLING(S) IN COLLEGE

(NOTE: Copy and complete a separate form for each sibling)

To NMF applicant: Please complete this section and request the registrar's office at colleges attended by sibling(s) (enrolled full-time only) to complete and return this form directly to National Medical Fellowships at the address below.

NMF Applicant's Name: ______________________ **SS#:** ______-_____-______
Address: ______________________ **Tel#:** ______________________
____

If this form is not received by the due date, NMF will assume that the sibling is not enrolled as a full time student, and the applicant's financial information will be adjusted accordingly.

TO BE COMPLETED BY APPLICANT'S SIBLING:

Name: ______________________ SS# ______-_____-______
(Please type or print clearly)

I authorize ______________________ to verify my enrollment information to National Medical Fellowships.
(Name of Institution)

Signature of sibling: ______________________ Date: ______________________

To be completed by school for the above named student:

The above named student is enrolled full time: ☐ Yes ☐ No

Dates of enrollment: From: ____________ to ____________

Degree or certificate sought: ______________________

Expected month/year of graduation: ______________________

Full name and address of school: ______________________
____
____

______________________ Authorized Signature ______________ Date

Affix School Stamp or seal here:

______________________ Print Name ______________ Title

Please return this form to:

National Medical Fellowships
5 Hanover Square
New York, NY 10004

Recommendation Form

To the Applicant: Please sign the consent statement below and give this form to someone who knows you well, such as a professor or employer, but not a relative or friend.

NMF Applicant's Name: ______________________________ **SS#** ______-_____-______
(Last) (First) (MI)

Address: ______________________________ **Tel#:** ______________

____

I herby consent that ______________________________ Furnish NMF with the information and evaluation requested
(Recommender)
below. In this connection, I hereby waive my right of access to said evaluation in accordance with the Family Educational Rights and Privacy Act of 1974.

Applicant's Signature: ______________________________ **Date:** ______________

To the Recommender: the above mentioned student has applied to NMF for a scholarship, award or fellowship. Your comments are important to the evaluation of the applicant

How long have you known the applicant? ______________________________

In what capacity do you know the applicant? ______________________________

Based on your experience with the applicant, please provide a statement on separate sheet explaining why you believe he or she is a good candidate for an NMF scholarship/award/fellowship.

Name: ______________________________

Signature: ______________________________

Title: ______________________________

Organization: ______________________________

Address: ______________________________

____

Please return this form to:

National Medical Fellowships
5 Hanover Square
New York, NY 10004

Financial Aid Transcript

Instructions: Applicants must submit the financial aid transcript to document financial aid received at medical school. Applicant should complete **Section A** and forward this to the financial aid offices of medical schools. If you are a first year and have not yet started medical school, please provide a copy of your financial aid offer.

Section A: To be completed by applicant

NMF Applicant's Name: ______________________ SS# ______-_____-______
(Last) (First) (MI)

I authorize the financial aid office at ______________________ which I have attended
(Name of School)

from ____________ to ____________, to provide the information requested in **Section B** to National Medical Fellowships, Inc.

Signature: ______________________

Address: ______________________

____

Section B: To be complete by medical school

A COMPLETE TRANSCRIPT IS NECESSARY IN ORDER FOR STUDENT TO BE CONSIDERED FOR AWARD

The award information requested below cannot be provided because the student:

☐ Did not Apply for aid ☐ Was not eligible for aid ☐ No funds available

☐ Other: ______________________

Sources of Assistance	Award Years and Amounts of Assistance				
	Year:_____	Year:_____	Year:_____	Year:_____	Year:_____
Federal Perkins					
Federal HPSL/PCL					
Federal Stafford-Subsidized					
Federal Stafford-Unsubsidized					
HEAL					
LDS					
Other Loans *(identify)*					
EFN					
NHSC Scholarship					
AFHPS					
BIA					
SSIG/State Grant					
FADHPS					
SDS					
NMF					
Institutional Grant					
Other Grants/Scholarships *(identify)*					
TOTAL GRANTS/SCHOLARSHIPS					
Expected Family Contribution					
Unmet Need					

Medical School Class Year: ____________

Please itemize the actual cost to be incurred by the student at your institution this year:

	Student Budget
Tuition	$__________
Fees	$__________
Room and Board	$__________
Indirect/Misc. Expenses	$__________
Total School Approved Budget	$__________

Is this student subject to higher non-resident tuition cost? ☐ YES ☐ NO

Comments:

____

____

____

____

Name:______________________________
(Please type or print)

Title:______________________________

School:______________________________

Telephone:(_____)______________ Date: ________

Signature:______________________________

Please return this form to:

National Medical Fellowships
5 Hanover Square
New York, NY 10004