



2011 Aetna/NMF Healthcare Leadership Program

The Aetna Foundation and NMF are pleased to announce a new Healthcare Leadership Program to help address the severe national shortage of physician-leaders who are committed to the health of underserved communities. The overall goal is to recognize the promise of minority students who have demonstrated leadership in medicine at an early stage in their professional careers as identified by their medical schools, acknowledged by Aetna through these scholarship funds, and showcased at NMF special events.

Eligibility and Selection Criteria:

Scholars must be 2nd and 3rd year medical students from underrepresented minority groups and must attend medical school in one of the following Aetna-targeted regions:

- California, particularly Los Angeles*
- Connecticut
- Illinois, particularly Chicago
- New Jersey
- New York, particularly New York City
- Pennsylvania, particularly Philadelphia

*California student application deadline: May 13th 2011

Please see the attached list of medical school partners. Awardees will have demonstrated evidence of community service and leadership potential at an early stage in their professional careers and a commitment to serving medically underserved communities.

Program Requirements:

Awards will be announced by Aetna officers at the NMF's **65th Anniversary Chicago and New York Galas**, which will be taking place on November 2011 and April 2012, respectively. If selected for this scholarship, scholars will be required to attend one of these celebrations. In addition, student scholars will be required to complete a survey after completion of each program year. Scholars must fulfill these requirements in order to receive their award.

Number and Value of the Awards:

This program will provide a \$5,000 scholarship to each of ten (10) awardees.

Application Procedure:

The application is contained within this package. Provide all information requested within the application and those items listed on the application checklist. Application materials should be sent in one package bound by paper clips. If you are unable to send all materials in one package please make a note on the application checklist of the date NMF should expect the remaining materials.

*Please **do not staple** any part of the application and please do not submit this application description. Your name, medical school and last four (4) digits of your social security number must appear on each additional document submitted with your application.*

Application Deadline:

Applications must be **postmarked by August 31, 2011**. Applicants will receive an email at the end of September confirming receipt of their application and their award status.

Aetna/NMF Healthcare Leadership Program
National Medical Fellowships, Inc.
347 Fifth Ave., Ste. 510
New York, NY 10016
212-483-8880x304
MBrito@nmfonline.org
Facsimiles will not be accepted



Aetna/ NMF Healthcare Leadership Program
List of Medical School Partners

California (Los Angeles)

Keck School of Medicine of the University of Southern California
University of California, Los Angeles David Geffen School of Medicine

Connecticut

University of Connecticut School of Medicine
Yale University School of Medicine

Illinois (Chicago)

Chicago Medical School at Rosalind Franklin University of Medicine & Science
Chicago College of Osteopathic Medicine of Midwestern University (Downers Grove)
Northwestern University The Feinberg School of Medicine
Rush Medical College of Rush University Medical Center
University of Chicago Division of the Biological Sciences, The Pritzker School of Medicine
University of Illinois College of Medicine

New Jersey

University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School
University of Medicine and Dentistry of New Jersey-New Jersey Medical School
University of Medicine and Dentistry of New Jersey -School of Osteopathic Medicine

New York (New York City)

Albert Einstein College of Medicine of Yeshiva University
Columbia University College of Physicians and Surgeons
Mount Sinai School of Medicine
New York University School of Medicine
New York College of Osteopathic Medicine of New York Institute of Technology
State University of New York Downstate Medical Center College of Medicine
Touro College of Osteopathic Medicine–New York
Weill Cornell Medical College

Pennsylvania (Philadelphia)

Drexel University College of Medicine
Jefferson Medical College of Thomas Jefferson University
Philadelphia College of Osteopathic Medicine
Temple University School of Medicine
University of Pennsylvania School of Medicine



2011 Aetna/NMF Healthcare Leadership Program

Application Checklist

- Complete and Signed Application
- Verification of Citizenship
- Proof of Ethnicity/Tribal affiliation
- Applicant's W2 and Tax Return
- Parent's W2 and Tax Return
- Financial Aid Award Offer
- Financial Aid Transcript
- Complete record (current and undergraduate) from the National Student Loan Data System & any other record of educational loans received. Please visit: http://www.nslds.ed.gov/nslds_SA/ to access your records;
- Two Medical School Faculty/Administration Recommendation Letters
 - Academic Recommendation
 - Leadership Recommendation
- Personal Statement
 - A personal essay on what leadership means for physician-leaders with details on health leadership activities to be continued during the scholarship period;
- Curriculum vitae
- Verification of Death/Divorce/Separation (applicant and parents)
- Proof of Medical School Enrollment
- Official Medical School Transcript

Please mail complete application packet, postmarked by **August 31st**, to:

Aetna/NMF Healthcare Leadership Program

National Medical Fellowships, Inc.

347 Fifth Ave., Ste. 510

New York, NY 10016

212-483-8880

MBrito@nmfonline.org

Facsimiles or Emails containing application will not be accepted



THE AETNA/NMF HEALTHCARE LEADERSHIP PROGRAM

Academic Year: 2011/2012

(Please type or neatly print in ink)

Name: _____
(Last) (First) (MI)

S.S. # _____ - _____ - _____

Current Address: _____
(Number, Street, Apt#)

Tel#: _____

(City, State, Zip Code)

Permanent Address: _____
(Number, Street, Apt#)

Tel 2#: _____

(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)

African American* Cambodian* Vietnamese* Alaska Native***

Native Hawaiian* Native American* Hispanic/Latino*: _____

Other*: _____

*Please provide proof of citizenship as well as ethnicity and ***if applicable tribal identification.

Medical School Information:

Name of Medical School:

Address:

Expected Date of receipt of MD or DO Degree:

Class Year:

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, or list in resume)

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

Please list extracurricular activities and community involvement. Include offices held, city & State. (Use additional sheets if necessary, or list in resume)

Employment Experience:

Name of Employer	Address	Position	Dates of Employment

Applicant Name: _____

Parental Information:

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

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

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Birthplace: _____

Birthplace: _____

Occupation: _____

Occupation: _____

Employer: _____

Employer: _____

Level of Education: _____

Level of Education: _____

Annual Gross Income: _____

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: _____ **Gross Annual Income \$** _____
(Name) (City & State)

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did or will your parents claim you as a US income tax exemption?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did or will you get more than \$1,200 worth of support from your parents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Income and Expense Information

	Parents	Applicant
1. U.S income tax return for this year has or will be filed by	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. This year's adjusted gross income from IRS tax form (if filling)	\$ _____	\$ _____
3. This year's income earned from work by (if not filling)	Mother \$ _____ Father \$ _____	Applicant \$ _____ 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 1000-1500 words discussing what leadership means to you as a physician-leader, with details on your experience with health leadership activities as well as those to be continued during the scholarship period. 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
347 Fifth Avenue Ste. 510
New York, NY 10016**



**VERIFICATION FORM FOR DEPENDENT SIBLING(S) IN COLLEGE
THE AETNA/NMF HEALTHCARE LEADERSHIP PROGRAM**

(NOTE: Complete a separate form for each sibling)

To NMF applicant: Please complete the top section of the form and have the registrar's office of your sibling's college (in which he/she needs to be enrolled full-time) complete and return this form directly to National Medical Fellowships at the address below.

NMF Applicant's Name: _____
Address: _____

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

SS# _____ - _____ - _____

I authorize _____ to verify my enrollment information for 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
347 Fifth Avenue Ste. 510
New York, NY 10016**



Recommendation Form

THE AETNA/NMF HEALTHCARE LEADERSHIP PROGRAM

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 hereby consent that _____ furnish NMF with the information and evaluation
(Recommender)
requested 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. Please sign over the sealed envelope.

Name: _____

Signature: _____

Title: _____

Organization: _____

Address: _____

Email: _____

Please return this form to:

**National Medical Fellowships
347 Fifth Avenue Ste. 510
New York, NY 10016**



Financial Aid Transcript

THE AETNA/NMF HEALTHCARE LEADERSHIP PROGRAM

Instructions: Applicants must submit the Financial Aid Transcript to document financial aid received at medical school. The applicant should complete **Section A** and forward this to their medical school's financial aid office.

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 completed 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

PLEASE ATTACH COPY OF FINANCIAL AID AWARD LETTER FOR CURRENT ACADEMIC YEAR

Comments:

Name: _____

(Please type or print)

Title: _____

School: _____

Telephone: (_____) _____ Date: _____

Signature: _____

Please return this form to:

**National Medical Fellowships
347 Fifth Avenue Ste. 510
New York, NY 10016**