



NEED BASED SCHOLARSHIP PROGRAM



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National Medical Fellowships, Inc. is a non-profit organization founded in 1946 dedicated to increasing the number of underrepresented minority physicians in the United States by providing financial support and other incentives to underrepresented minority medical students, and to articulating the vital role that minority physicians play in the well-being and productivity of our nation. NMF accomplishes its mission by focusing on programs that will:

- Improve the health of underserved communities by increasing the representation of minority physicians, educators, researchers, policymakers, and health care administrators in the United States;
- Train minority medical students to address the special needs of their communities; and
- Educate the public and policymakers about the public health problems and needs of underserved populations.

The Need-Based Scholarship Program provides financial assistance to United States citizens from groups currently under represented in the medical profession; specifically, African-Americans, Alaska Natives, Hispanic/Latinos, Native Hawaiians, and mainland Puerto Ricans who permanently reside within the 50 U.S states. All Applicants must submit proof of citizenship.

Eligibility requirements:

Eligible candidates must be first or second year medical students. Students must provide proof of admission to an accredited medical school (letter of acceptance for first year medical students, academic transcript for second year medical students). Applicants must demonstrate and document financial need by submitted, complete copies of their parents', spouse's and their own most recent 1040, 1040A or 1040EZ tax forms and W2. All nontaxable income (e.g. AFDC, ADC, Social Security benefits, Etc.) must also be documented by the appropriate agency. Applicants must submit a current financial aid award letter. Applicants lacking evidence of taxable or nontaxable income must provide verification of means of support. All parental financial data must be submitted in order to evaluate dependant status.

Application and Selection Criteria:

A rigorous application process ensures that assistance is provided to students with the greatest documented need. Scholarships are granted on the basis of financial need as determined by the student's total resources (including parental and spouses support), cost education, and receipt of other scholarships and grants.



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Application Procedure:

The application is contained within this package. Please type or neatly print in black ink.

Provide all information requested. Your application should contain all application materials in the order requested and be bound by paper clips. Do not staple any part of the application. Do not submit this application description.

Your name, medical school and last four (4) digits of your social security number must appear on each extra page submitted with your application.

Application material must be sent to NMF at the address listed at the end of this description.

Review Process:

NMF will evaluate all application for completeness. The materials needed for a complete application are detailed in the accompanying application form.

NMF objectively reviews each of the application based on the candidate's credentials, recommendations, interest, community service, and financial need.

Applicants should be notified or final decision by January 31, 2011.

Number and Value of Award Presented:

The number of scholarship varies based on annual budget constrictions. Awards range from \$1,000 to \$10,000.

Application Deadline:

Applications must be postmarked by August 31, 2010. Applicant will be notified by September 17, 2010 via email that their application was received. Please do not contact NMF about application status.

For additional information please contact:

National Medical Fellowships, Inc.
Need Based Scholarship Program
347 Fifth Avenue, Ste. 510
New York, NY 10016

Phone: (212) 483.8880 x304
E-Mail: NMF1@NMFonline.org
WEB: NMFonline.org



Need Based Scholarship Checklist:

- Complete and sign application form
- Applicant's W2 and Tax Return
- Parent's W2 and Tax Return
- Financial Aid Transcript
- Recommendation Letter
- Personal Statement
- Verification of Citizenship
- Verification of Death/Divorce/Separation (applicant and parents)
- Proof of Ethnicity/Tribal affiliation
- Verification Form for Sibling(s) in College
- Proof of Enrollment
- Financial Aid Award Offer

Please mail complete application to:

National Medical Fellowships
Attn: Need Based Scholarship Program
347 Fifth Avenue, Ste. 510
New York, NY 10016



Scholarship/Award Program Application Form
(Please type or neatly print in black ink)

THE NEED BASED SCHOLARSHIP PROGRAM

Academic Year: 2010/2011

Name: (Last) (First) (MI)

S.S. # - -

Current Address: (Number, Street, Apt#)
(City, State, Zip Code)

Tel#: _____

Permanent Address: (Number, Street, Apt#)
(City, State, Zip Code)

Tel 2#: _____

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 provides proof of citizenship and (if applicable) tribal identification.

Medical School Information:

Name of Medical School:

Address:

Expected Date of receipt of MD or DO 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)

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 600 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
347 Fifth Avenue, Ste. 510
New York, NY 10016**



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: _____
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 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
347 Fifth Avenue, Ste. 510
New York, NY 10016**



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 hereby consent that _____ (Recommender) Furnish NMF with the information and evaluation 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.

Name: _____

Signature: _____

Title: _____

Organization: _____

Address: _____

Please return this form to:

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



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 <i>(identify)</i>					
EFN					
NHSC Scholarship					
AFHPS					
BIA					
SSIG/State Grant					
FADHPS					
SDS					
NMF					
Institutional Grant					
Other Grants/Scholarships <i>(identify)</i>					
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
347 Fifth Avenue, Ste. 510
New York, NY 10016**