



UNIVERSITY OF ARKANSAS COLLEGE OF MEDICINE: **2018-19**

SCHOLARSHIP APPLICATION

for Continuing Medical Students (*rising sophomores, juniors, & seniors*)

Please email completed application to Tom South, Assistant Dean, Medical Student Admissions, College of Medicine. southtomg@uams.edu

APPLICATIONS RECEIVED AFTER MAY 15 WILL NOT BE CONSIDERED.

PLEASE DOWNLOAD AND INSTALL THE MOST RECENT VERSION OF ADOBE ACROBAT READER (FREE SOFTWARE FOR PC AND MAC COMPUTERS) and SAVE WITH A NEW FILE NAME. IF THIS IS NOT DONE, THE FORM WILL NOT SAVE PROPERLY.

IF YOU WISH TO BE CONSIDERED FOR A "NEED-BASED" SCHOLARSHIP, COMPLETE THE "FAMILY INFORMATION" SECTION.

STUDENT NAME: _____ CLASS YEAR for **2018-19**: (check one) ___ M2 ___ M3 ___ M4

AGE: ___ SEX: ___ RACE: ___ HOMETOWN: _____ COUNTY: _____

MARITAL STATUS: _____ NAMES / AGES OF ANY DEPENDENTS: _____

IF MARRIED, IS SPOUSE A STUDENT? ___ SCHOOL: _____ GRADUATION DATE: _____

IS SPOUSE EMPLOYED? ___ EMPLOYER: _____ ANNUAL SALARY: \$ _____

UNDERGRADUATE / GRADUATE SCHOOL(S) AT WHICH YOU RECEIVED YOUR DEGREE(S):

SCHOOL: _____ MAJOR: _____ GPA: _____ YEAR GRAD.: _____

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Please provide information ONLY for the time period since entering medical school

MEMBERSHIP/ LEADERSHIP including elected positions: _____

AWARDS: _____

RESEARCH EXPERIENCE: _____

COMMUNITY SERVICE / VOLUNTEERISM / UAMS ACTIVITIES: Only include activities you have participated in since you started medical school (i.e., community, free clinics, church, civic, or school activities including ASG, SAC, Volunteer Fair, Phonathon, Freshman Family Day, Admissions Interview Day Tour Guide, clubs, interest groups, organizations, etc..) Please specify the beginning **year** of involvement as well as the **frequency** (i.e., one time only, once a week, etc.) and **length** (i.e., one day, six months, etc.) of involvement. For non-UAMS activities, please provide a phone number for each contact person in the event the Committee needs additional information.

FAMILY INFORMATION: PARENTS ARE: (check one) ___ Married ___ Separated ___ Divorced ___ Deceased

FATHER: Occupation: _____ MOTHER: Occupation: _____

Address: (City/State): _____ Address: (City/State) _____

Employer: _____ Annual Income: \$ _____ Employer: _____ Annual Income: \$ _____

Ages of siblings living at home: _____ # of siblings who will be enrolled in college at least half time during 2018-19: _____

FINANCIAL NEED:

TOTAL EDUCATIONAL INDEBTEDNESS AS OF MAY 15: \$\$ _____

LIST ANY NON-INSTITUTIONAL SOURCES OF FINANCIAL AID YOU EXPECT TO RECEIVE DURING 2018-19:

PLEASE LIST ANY **SPECIAL CIRCUMSTANCES** YOU WISH TO BE CONSIDERED:

Certification and Signature:

I certify that the information on this application is a truthful statement of my academic achievements, honors, awards, memberships, extracurricular activities, employment and research experience, community/volunteer service, family information and financial need.

SIGNATURE

DATE

Typing your FULL NAME and the DATE will be your certification of this application.

I give permission to the College of Medicine Admissions Office to provide a photocopy of this application to non-UAMS Scholarship Committees who request nominations for private foundation/professional organization scholarships: ___ YES ___ NO