UNIVERSITY OF ARKANSAS COLLEGE OF MEDICINE: **2019-20**

SCHOLARSHIP APPLICATION

For Entering **Freshmen** Medical Students

REFER TO INSTRUCTIONS ON FINANCIAL AID/SCHOLARSHIP SHEET IN YOUR ACCEPTANCE PACKET BEFORE FILLING THIS FORM OUT ELECTRONICALLY. SUBMITTING FORMS WITH FORMATTING ERRORS MAY DELAY YOUR APPLICATION BEYOND THE DEADLINE DATE AND YOU WILL NOT BE CONSIDERED FOR A SCHOLARSHIP. MOST ISSUES ARISE FROM NOT READING THE INSTRUCTIONS AND NOT INSTALLING A CURRENT VERSION OF ADOBE ACROBAT READER.

RETURN THIS SCHOLARSHIP APPLICATION BY EMAILING THE COMPLETED FORM TO
Tom South, College of Medicine
Assistant Dean of Medical Student Admissions
University of Arkansas for Medical Science
SouthTomG@uams.edu

BY MARCH 15 TO BE CONSIDERED
PLEASE DO NOT SUBMIT ADDITIONAL DOCUMENTS OR ATTACHMENTS

STUDENT NAME: _____ CLASS YEAR FOR **2019-20:** **Freshman**

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, THE STUDENT, RECEIVED YOUR DEGREE(S):

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

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

MEMBERSHIP/ LEADERSHIP including elected positions:

HONORS / AWARDS:

EMPLOYMENT:

RESEARCH EXPERIENCE:

COMMUNITY SERVICE / VOLUNTEERISM/MENTORING: (community, church, civic, or school activities). Please specify **year** 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. 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

(You must complete this section if you wish to be considered for any "need-based" scholarships)

FATHER: Occupation: _____ **MOTHER**: Occupation: _____

City/State: _____ 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 2019-20: _____

FINANCIAL NEED:

TOTAL PROJECTED EDUCATIONAL INDEBTEDNESS Prior to May 15, 2019: $ _____

LIST ANY NON-INSTITUTIONAL SOURCES OF FINANCIAL AID YOU EXPECT TO RECEIVE DURING 2019-20:

_____

_____

IF YOU HAVE **SPECIAL CIRCUMSTANCES** WHICH YOU FEEL SHOULD BE CONSIDERED IN EVALUATING YOUR REQUEST FOR A SCHOLARSHIP, PLEASE LIST THESE BELOW:

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

_____

Signature *Typing your name on the line above will be your signature*

Date

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

Revised 1-2-2019