Hospital for Special Care Foundation

MEDICAL STUDENT SCHOLARSHIP APPLICATION - 2020

Last 4 digits of Social Security # __ __ __ __

GENERAL INFORMATION

Hospital for Special Care (HFSC) welcomes **THIRD YEAR** medical students to apply for the **2020** **Medical Student Scholarship**.

Applications for the scholarship must be **postmarked by April 3, 2020**. Applications postmarked after this date will not be considered. This application becomes complete and valid ONLY when applicants have returned all documentation indicated on the checklist **on page 2.**

This scholarship is funded through a private donor and will be awarded to a medical student who will begin **the FOURTH YEAR** of medical school studies **September 2020** and meets the following eligibility criteria.

ELIGIBILITY REQUIREMENTS - $12,000 will be awarded to one student who meets the following criteria:

- Must demonstrate financial need.
- Must be a US citizen residing in Connecticut.
- Preference is given to students in active military services, who are veterans, or who have a parent, a grandparent or a great-grandparent who served in WWII. ***However, students without military affiliations are eligible and encouraged to apply.***
  (Must provide proof that student has served or will be serving; or proof that one or more of the above listed relative(s) has served.)
- Please **type** the information requested. All responses must be completed on this form. Use only the space provided for your answers. Please DO NOT submit a CV or additional pages.

NOTIFICATION AND AWARDS

The recipients will be notified in June, and the awards will be sent directly to the school by September.

SUBMIT ALL MATERIALS TO:

Hospital for Special Care Foundation, Inc.
Attn. Kathleen Altieri, Administration
2150 Corbin Avenue, New Britain, CT 06053

Applications MUST be postmarked by Friday, April 3, 2020

For more information, please call 860-832-6257.

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APPLICANT INFORMATION

This is the ONLY area of the application where your identifying information will appear. Please use only the last ***four digits of your social security number as identifier*** on all subsequent pages and attachments.

Name (first):_____ (middle):_____ (last): _____

Street Address: _____

City: _____ State:_____ Zip: _____

E-mail: _____Home Phone: _____ Mobile: _____Date of Birth: _____

I am a US citizen: YES: ____ NO:_____ I have lived in Connecticut since (date): _____

CHECKLIST

Before you return your application package, please verify that you have enclosed the following documentation..
Any incomplete applications will be disqualified.

- ❒ Applicant information (this page), page 2
- ❒ Academic profile/history, page 3
- ❒ Employment/extracurricular/community services/others, page 4
- ❒ Student financial statement, page 5

Please include the following:

- ❒ A personal statement essay, describing career goals and future aspirations. Limit to 400 words. Please use regular white paper, double-spaced, one inch margins.
- ❒ Medical school transcript(s) – copy/unofficial transcripts/score is acceptable

Two letters of recommendation:

- ❒ One from a faculty member (must be sealed in an envelope and signed across sealed flap).
- ❒ One from someone of your choosing – NOT a family member (must be sealed in an envelope and signed across sealed flap).

CERTIFICATION SECTION

In submitting this application, I certify that the information provided is complete and accurate to the best of my knowledge. If requested, I agree to submit proof of information I have provided on this form. Falsification of information may result in termination of any scholarship granted. This application and attached materials become the property of Hospital for Special Care Foundation, Inc.

Applicant's Signature: _____ Date: _____

ACADEMIC PROFILE/HISTORY

Instructions: This section must be completed and signed by an official of your school.

MEDICAL COLLEGE/ UNIVERSITY CURRENTLY ATTENDING: 2020-2021

School:_____ City: _____ State: _____

Status for the September **2019** academic year: ❑ 4th Year Medical Student

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ACADEMIC HISTORY

COLLEGE: Name/Location _____

Year graduated: _____ Degree:_____ Major: _____

GRADUATE SCHOOL (If applicable) Name/Location _____

Year graduated: _____ Degree:_____ Major: _____

ACADEMIC HONORS: List academic honors received in College and Medical School. Limit to the ten most recent.

NAME: DATE RECEIVED:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

EMPLOYMENT HISTORY, EXTRACURRICULAR ACTIVITIES, AWARDS, OTHER

Employment (Limit to 5; please start with most recent):
Indicate any full-time or part-time position held. Note if this was summer employment

DATES EMPLOYED EMPLOYER TITLE HRS./WK.

Publications (Limit to 5; please start with most recent):

Research Projects (Limit to 5; please start with most recent):

Community Service List volunteer work or community service activities without pay - (Limit to 5; please start with most recent):
ORGANIZATION ACTIVITY/EVENT YEAR(S) PARTICIPATED TOTAL HOURS VOLUNTEERED

Awards/Other (Limit to 5; please start with most recent):

Applicant signature Date

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STUDENT FINANCIAL STATEMENT: To be completed by financial aid officer:

Name of student:_____

Medical School: _____ Year to graduate: _____

Marital Status: _____ Number of dependents: _____

Spouse/Partner occupation: _____ Number of siblings in college/graduate school: _____

Parent(s) occupation(s): _____

Was student listed as an "exemption" on parent's income tax return last year? ___YES ____NO

PROJECTED 2020-2021 BUDGET:

Expenses	**Applicant**	**Spouse/Partner**
Tuition		
Living expense		

Living expense include books, educational supplies, rent/housing, food, clothing, transportation/car, medical/dental insurance and miscellaneous costs.

Income	**Applicant**	**Spouse/Partner**
Earned		
Gifts and/or grants		

Debt	**Applicant**	**Spouse/Partner**
Current pre-medical debt		
Current medical school debt		

Total debt to date		
Projected debt at graduation		

Please describe how the applicant's spouse/partner, parent(s), and/or family members are assisting with expenses:

_____

_____

_____

Explain below any unusual financial circumstances in your household (may attach a page if space below is insufficient)

_____

_____

_____

_____

Signature of applicant/date: _____

Name of financial aid officer (Please print): _____

Signature of financial aid officer/date: _____