Hospital for Special Care Foundation

FLORENCE TIMURA MEDICAL STUDENT SCHOLARSHIP APPLICATION - 2024

Last 4 digits of Social Security # _____

GENERAL INFORMATION:	
Hospital for Special Care (HFSC) welcomes **THIRD YEAR** medical students to apply for the **Florence Timura 2024 Medical Student Scholarship**. This scholarship honors the memory of Florence Timura and is made possible through an established charitable fund. The scholarship will be awarded to a medical student beginning **the FOURTH YEAR** of medical school studies **September 2024,** and meeting the eligibility criteria below.	
SCHOLARSHIP AMOUNT:	▪ One scholarship in the amount of **$12,000** will be awarded

ELIGIBILITY REQUIREMENTS:

This scholarship is open to:

- Students from Connecticut (i.e. completed secondary or undergraduate education in Connecticut; students whose permanent residence is in Connecticut); **OR**

- Students attending one of the following medical schools in Connecticut: The University of Connecticut (UCONN) School of Medicine, Yale School of Medicine, or Quinnipiac School of Medicine.

ADDITIONAL ELIGIBILITY REQUIREMENTS:

- Must demonstrate financial need.
- Must be a US citizen.
- *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.

APPLICATION SUBMISSION INSTRUCTIONS AND DUE DATE:

Applications for the scholarship must be **postmarked by April 15, 2024**. 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.**

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.

SUBMIT ALL MATERIALS TO:	**Hospital for Special Care Foundation, Inc.** **Attn. Gianna Gordon** **2150 Corbin Avenue, New Britain, CT 06053**
NOTIFICATION AND AWARD:	The recipient will be notified in May, and the award will be sent directly to the school by September.

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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:**
Email:	**Preferred Phone:**	**Alt. Phone:**
Date of Birth:	**US Citizen:** ☐ Yes ☐ No	

Check all that apply *(only one required for eligibility)***:**

☐ I am a student from Connecticut.

☐ I attend one of the following medical schools in Connecticut: The University of Connecticut (UCONN) School of Medicine, Yale School of Medicine, Quinnipiac School of Medicine.

CHECKLIST:

Before you return your application package, please verify that you have enclosed the following documentation. Incomplete applications will be disqualified and will not be reviewed.

Check each box to verify completion:

☐ Completed Application (please complete all sections on pages 2-6)

Please include the following:

☐ A personal statement essay, describing career goals and future aspirations. Limit to 400 words. Please use page 6 provided or regular white paper, double-spaced, with one inch margins.

☐ Medical school transcript(s) – copy/unofficial transcripts/score is acceptable

Two letters of recommendation: (must be sealed in an envelope and signed across sealed flap)

☐ One from a faculty member

☐ One from someone of your choosing – NOT a family member

CERTIFICATION:

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.**

School Official Signature: _____ Title: _____

MEDICAL COLLEGE/ UNIVERSITY CURRENTLY ATTENDING: 2023-2024

School:_____ City: _____ State: _____

Status for the September **2024** academic year: ☐ 4th Year Medical Student

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):

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 2023-2024 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):

Applicant's Signature: _____ Date: _____

Name of financial aid officer (Please print): _____

Signature of financial aid officer: _____ Date: _____

PERSONAL STATEMENT: Please describe career goals and future aspirations (limit 400 words):