WELSFORD AND MILDRED CLARK
MEDICAL MEMORIAL SCHOLARSHIP FUND

APPLICATION
Applications properly completed and signed should be returned to: Waterbury Medical Association, One Regency Drive, P.O. Box 30, Bloomfield, CT 06002.

GENERAL INFORMATION AND ELIGIBILITY REQUIREMENTS
Scholarships are granted upon application to those students who seem best to satisfy the requirements of the Welsford and Mildred Clark Medical Memorial Trust Fund in the amount of up to $20,000 within the limits of the funds available. Review of applications and the selection of winners have been assigned by the Trust Fund to the Waterbury Medical Association.

The eligibility requirements for this scholarship award are:

1. Resident of Connecticut for five years. If you did not attend high school in Connecticut, please explain how you meet this requirement and state where you are registered to vote.
2. Third-year (M.D., D.O.) medical students (Scholarship Award to cover 4th year costs).
   (IF student is graduating after 3 years, application must be received during the second year of medical school)
3. Enrollment in a not-for-profit medical school accredited by the AMA and/or the World Health Organization.
5. Academic excellence determined by a copy of the applicant’s transcript and the results of participation in Part I of the National Boards.
6. Extracurricular interests and community service.
7. Letters of recommendation from two faculty members and your Dean submitted directly to the Committee.
8. Statement of the applicant’s method of financial support during the previous years of medical school including a personal income statement of the applicant and spouse, if married.
9. A written statement concerning the applicant’s plan for his or her medical career.

1/2010
Completed applications will be accepted through April 30 of the applicants third year in medical school. Winners will be announced on July 1 of the same year.

**THE FOLLOWING QUESTIONS MUST BE ANSWERED BY ALL APPLICANTS**

In order to judge your degree of need and your qualifications, the following specific information is required. So far as practicable, it will be regarded as confidential. In view of the facts set forth below, I hereby make application for financial aid for the year 20____ to 20____ in accordance with the conditions specified above which I have read.

Legal name in full______________________________

Anticipated year of M.D. degree_______________________

1. Local address for the coming school year:
   Street__________________________________________
   City____________________ State/Zip____ Phone______
   Home address:
   Street__________________________________________
   City____________________ State/Zip____ Phone______

2. Name & Address of High School_______________________
   Ranking in your graduating class_____________________

3. Premedical education (College or University):______________
   Quality Point Average:____________________________

4. Medical School:___________________________________
   Name of Financial Aid Officer at Medical School________

5. Father’s (or guardian’s) name in full______________________ Living____
6. Mother’s maiden name in full____________________________ Living____

7. Father’s occupation____________________________________
8. Mother’s occupation____________________________________

9. Your date of birth (MM/DD/YYYY)_______________________

10. Country of birth_______________________________________

11. If foreign born, are you a naturalized citizen of the United States?________

12. Please explain how you have been a legal resident of Connecticut for five years prior to applying. Where are you registered to vote?
    ___________________________________________________
13. Total annual gross income of parents or trust funds
$_________ earned by _______ individuals.
(Note: No application will be considered unless this information is provided.)

14. Number of dependents supported wholly or in part from incomes stated under Question 13.

15. Are you married? ______ Do you contribute to the support of others? ______
If so, explain circumstances.

________________________________________________________________________

16. State below plans towards self-support for the coming year.

________________________________________________________________________

17. Please list any other scholarship awards or assistance you have received during medical school.

________________________________________________________________________

18. Give as personal references the full names and addresses of two present members of your medical school faculty and the Dean. Please be sure all three letters are sent directly to the Committee.

________________________________________________________________________

________________________________________________________________________

19. Please list extracurricular interests and/or community service.

________________________________________________________________________

________________________________________________________________________

20. Give details of present indebtedness? This may be included with personal finance statements. (see below) You must write the total amount of your indebtedness here.

________________________________________________________________________

21. Please state in 150 words or less on an attached 8½ x 11 sheet of paper, your plans for your medical career, including area of specialization, type of practice and location of practice.
22. Please include the following with this completed application.
A. Medical school transcript
B. Results of Part I of the Medical Boards
C. Personal financial statement of applicant and spouse, if married
D. Complete statement of medical school expenses – tuition, room, board, books, etc. for the first three years of medical school

CERTIFICATION
(1) I hereby certify that I will use the proceeds of the scholarship only for payment of tuition and required feed, room and board, the purchase of books, instruments and other necessary school supplies and equipment.
(2) I hereby acknowledge that the information submitted herewith is true and correct.

Signature_________________________________________________________Date____________________

For office use only

ACTION ON APPLICATION

1. Scholarship approved in the amount...........................$________________
2. Scholarship denied – explanation: _____________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

Date____________________

Waterbury Medical Association Official:

________________________
Chairman, Selection Committee