The Foundation of Collier County Medical Society
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Dr. William Lascheid Memorial Scholarship for Medical Students
APPLICATION 2018

Please return your application to the address, email, or fax # above by March 31, 2018

The scholarship offered by the Foundation of Collier County Medical Society honors and remembers CCMS Past President and Neighborhood Health Clinic co-founder Dr. William Lascheid, his many contributions to the medical community, and his tireless efforts to provide care to the underserved in Collier County. Eligible Florida residents* enrolled in or accepted to medical school, who have demonstrated excellence in service to their community, may apply. Recipients are selected by the Foundation upon review of the application and supporting materials. The dollar amount of scholarship(s) may vary dependent upon available Foundation funds. **Must be a bona fide resident of Florida for at least 12 months prior to enrollment in medical program (not including time spent attending an undergraduate/graduate school in Florida).*

Application Instructions

Please type the information requested. All responses must be completed on this form. Use only the space provided.

The entire application must include:

- ☐ Completed application form
- ☐ Personal statement from the applicant reflecting on participation in community service efforts, motivation for becoming a physician, and what applicant hopes to accomplish in the medical field (max. 800 words)
- ☐ Letter of recommendation from a faculty member
- ☐ Letter of recommendation from a community service provider
- ☐ Medical school transcript or final transcript from pre-medical study (copy or unofficial transcript acceptable)

Personal Information

Applicant's Name _____

Medical School Name _____

Current Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell_____ Email _____

DOB ____ ____ _____ Permanent Resident of Florida ☐ Yes ☐ No Citizen of the U.S. ☐ Yes ☐ No

The Foundation of Collier County Medical Society, Inc. is a 501(c) (3) organization, State of Florida Registration No. CH38165. Tax ID No. 46-1391700
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BY CALLING TOLL-FREE 1-800-435-7352. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THE STATE

Education

High School

Name / Location (city & state) _____

_____

Year Graduated _____ GPA _____ SAT Verbal _____ Math _____ ACT Scores _____

Class Rank _____ Percentile _____ Class Size _____

Academic Honors, Athletic & Extracurricular Activities, Clubs, Offices Held, Research Projects, Publications

College

Name / Location (city & state) _____

_____

Year Graduated _____ Degree_____ Major _____ GPA _____

Academic Honors, Athletic & Extracurricular Activities, Clubs, Offices Held, Research Projects, Publications

Graduate School

Name / Location (city & state) _____

_____

Year Graduated _____ Degree_____ Major _____ GPA _____

Academic Honors, Athletic & Extracurricular Activities, Clubs, Offices Held, Research Projects, Publications

Medical School

Name / Location (city & state) _____

_____

Class Year _____ Degree_____ Major _____ GPA _____

Academic Honors, Athletic & Extracurricular Activities, Clubs, Offices Held, Research Projects, Publications

Other

Name / Location (city & state) _____

_____

Year Graduated _____ Degree_____ Major _____ GPA _____

Academic Honors, Athletic & Extracurricular Activities, Clubs, Offices Held, Research Projects, Publications

Community Service / Volunteer Work

Organization/Location _____

_____

Start Date _____ End Date _____ Approximate # of total hours contributed_____

Description of work provided

Organization/Location _____

_____

Start Date _____ End Date _____ Approximate # of total hours contributed_____

Description of work provided

Organization/Location _____

_____

Start Date _____ End Date _____ Approximate # of total hours contributed_____

Description of work provided

[add additional sheets if necessary]

Student Financial Statement

Employment Status ☐ Full time ☐ Part time ☐ Seasonal ☐ None

Name/Location of Employer (if applicable) _____

Start Date _____ Position _____ Wage _____

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Other_____ Number of Dependents _____

Spouse/Partner Occupation _____

Was student listed as an exemption on parent's income tax return last year? ☐ Yes ☐ No

Expenses	Applicant	Spouse/Partner
Tuition		
Living Expense		

Income	Applicant	Spouse/Partner
Earned Income		
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 will assist in the costs of the applicant's medical education.

Please describe any extenuating circumstances which demonstrate financial need.

_____ _____

Signature of applicant Date

_____ _____

Signature of financial aid officer Date