



The Foundation of Collier County Medical Society  
88 12th St N Unit 200, Naples FL 34102  
T (239) 435-7727 F (239) 435-7790  
info@ccmsonline.org ccmsfoundation.org

## Dr. William Lascheid Memorial Scholarship for Medical Students APPLICATION 2022

**Please return your application to the address, email, or fax # above by March 31, 2022**

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

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  
A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES  
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.

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Signature of applicant

Date

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Signature of financial aid officer

Date