



SOUTHERN MEDICAL ASSOCIATION ALLIANCE



SOCIETY OF 1924
MEDICAL SCHOOL SCHOLARSHIP

APPLICATION

Applicant Must Submit:

- The completed scholarship application form and any related documents
- A letter, on school letterhead, from the applicant's medical school verifying that he/she is enrolled full time as a medical student at that institution
- An official copy of the applicant's current transcript

Please print or type

Name of Student Applicant: _____

Address _____

City _____ State _____ Zip _____

Date of Birth: _____

Phone: _____ Is this ___ Home ___ Work ___ Cell?
Please list the best number at which you can be reached if there are questions.

Email(s): _____

Name of Spouse (if applicable): _____

Spouse's Email: _____

Name and address of medical school now attending: _____

Class Standing (if available): _____ GPA or equivalent: _____

Are you currently a member of the Southern Medical Association? ___ Yes ___ No

If no, would you like to be? Membership is FREE to Medical Students. ___ Yes ___ No

Are you currently a member of your County Medical Society? ___ Yes ___ No

Are you currently a member of your State Medical Society? ___ Yes ___ No

Application Requirements- The following 5 items must be provided for your application to be accepted. Remember to enclose all related documents with application.

- 1) **Financial Need/Use of Funds:** *Describe any specific needs or individual circumstances that affect your current ability to finance your education and explain how funds available will be used:*
- 2) **Career Goals in Medicine:** *Describe and outline your specific individual medical career goals.*
- 3) **Leadership Qualities:** *Describe your specific leadership skills or activities in which you have already had the opportunity to enhance your development as a healthcare leader.*
- 4) **Activities, Honors & Awards:** *List any collegiate honors or awards you have received as well as your participation in other leadership activities, community involvement, or volunteer activities; publications or participation in medical research projects; etc.*
- 5) **Other Interests:** *Please feel free to note any additional information or personal interests you would like the review committee to consider.*

Required information checklist:

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Applicant Signature:

By signing below, I acknowledge that the information I have provided in this application is accurate and correct and I understand it may be subject to verification by the Southern Medical Association Alliance Society of 1924 Scholarship Committee.

Student's Signature

Date

APPLICATION DEADLINE:

DO NOT DELAY!

Applications received at the address below by September 22nd will be accepted

Submit Application to:

Southern Medical Association Alliance
Society of 1924 Scholarship Review Committee
3500 Blue Lake Drive, Suite 360 | Birmingham, AL 35243
(800) 423-4992 Phone | (205) 945-1830 Fax | www.smaalliance.org

For Committee Use: