The Dr. William Jones Mc Elhiney Medical School Scholarship Application

Presented by:
St. Charles – Lincoln County Medical Society
&
Missouri State Medical Association
(the application can be found and completed at www.sclcms.org)

Name _____

Home Address: _____

_____
City State Zipcode

Applicant's Phone Number _____

Applicant's Email Address _____

Parents' Name _____

Expected year of graduation from medical school_____

Missouri Medical School _____

School Address_____
City State Zip Code

St. Charles-Lincoln County High School you attended_____

College Education _____

Year of Graduation from College _____ Major _____ Grade Point Average _____

Place of Birth _____

US Citizenship? [ ] Yes [ ] No If not a US citizen, are you a permanent resident? [ ] Yes [ ] No

Candidate # _____

What is your anticipated field of practice in Medicine? _____
_____

Honors, awards, significant achievements from high school, college and/or medical school_____
_____

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Your work history, including summer jobs, volunteerism, etc. _____
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_____

Community Involvement _____

_____

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_____

Father's occupation _____ Annual Income _____
Mother's occupation _____ Annual Income _____

Sibling(s) _____
Number of sibling(s) in college, professional or graduate school _____

Do you plan to practice medicine in St. Charles or Lincoln County? [ ] Yes [ ] No
Do you plan to practice medicine in the State of Missouri: [ ] Yes [ ] No
Do you belong to the student MSMA or AMA? [ ] Yes [ ] No

Professional References (*Please provide two – please give name, address and contact telephone number)*

Reference #1

_____
_____
_____
_____

Reference #2

_____
_____
_____
_____

Are you married [ ] Yes [ ] No OR plan to marry during the current academic year: [ ] Yes [ ] No __
Date of pending marriage _____

What is the value of assets owned by you and/or spouse?
Savings Account $ _____ Stocks & Bonds $ _____ Real Estate Equity $ _____
Trust Fund(s) $ _____ Other (*provide complete information on a separate sheet and attach to application)*
Total Assets $ _____
What is the value of your current debt?
Consumer debt - Applicant $ _____ Spouse $ _____
Education debt - Applicant $ _____ Spouse $ _____
Other debt *(please explain)* Applicant $ _____ Spouse $ _____
What is the year of the automobile you drive? _____ Make of auto _____ Model _____
Unpaid balance of auto loan $ _____ Monthly payment $ _____

How much financial assistance do you expect to receive this year from your parents? _____
From other relatives, friends? _____
How much $?_____
Source? _____

I hereby permit the St. Charles – Lincoln County Medical Society to use biographical, academic and financial information contained in this application to determine a possible award for which other students are also applying.

I declare and certify that the information on this document is complete and correct.

_____ _____
Signature Date

Or

[ ] I accept these terms (if completing application electronically) Date _____
[ ] I decline these terms (if completing application electronically) Date _____

Return your completed Scholarship Application
No later than
October 27, 2017
Mail to:
Martin L. Willman, MD
2304 Todforth Way
Saint Louis MO, 63131
or
Fax to: 636-528-1606
or
Email to:
willmanm@gmail.com