

**THE POLISH-AMERICAN MEDICAL SOCIETY
IN CHICAGO
APPLICATION FOR EXAMINATION SCHOLARSHIP
Closing date for submission – January 15 and July 15 each year
Announcement of awards – March and September 15 each year**

1. Name: _____
2. Mailing address: _____

Telephone: (_____) _____ - _____
E- Mail: _____
3. Permanent address: _____

Telephone: (_____) _____ - _____
4. Current address: _____

Telephone: (_____) _____ - _____
5. Country of birth: _____
6. Date of birth: _____
7. Marital Status: Single Married Divorced Widowed
8. Residency status: U.S. Citizen U.S. Resident Polish Citizen Other (explain)

9. Current occupation
Position: _____
Address: _____
Telephone: (_____) _____ - _____
Fax: (_____) _____ - _____
10. Family background
Father's name: _____
Date of birth: _____
Place of birth: _____
Ethnic background: _____
Occupation: _____
Present address: _____

Telephone: (_____) _____ - _____
Mother's name: _____
Date of birth: _____
Place of birth: _____
Ethnic background: _____
Occupation: _____
Present address: _____

Telephone: (_____) _____ - _____

If married, husband's name or wife's given & maiden name:

Date of birth: _____

Place of birth: _____

Ethnic background: _____

Occupation: _____

Present address: _____

Telephone: (_____) _____ - _____

11. School History

Institutions – High School & above	From	To	Degree Recived	Date	Study Major	Study Minor

12. Medical school: _____

Date of graduation: _____

13. You will be enrolled at:

Name of the course: _____

Address of the course: _____

14. What are your present educational and professional plans?

What salary or financial grants do you presently have, if any?

15. Describe your proposed course of study and residency plans:

16. What other scholarships or grants will you receive, or for what other grants are you applying?

How much financial aid will you receive from your spouse, parents or other sources?

17. List honors and distinctions you have achieved:

18. Have you had any articles, theses or books published? If so, please indicate their titles, place and date of publication. (Use additional paper if necessary)

19. How would you rate your knowledge of English?

__ None __ Poor __ Fair __ Good __ Excellent

20. What have been your interests and activities outside your studies or work?

(Use additional paper if necessary)

21. List two (2) professors under whom you have studied or two (2) persons who can attest to your character as well as to your academic or professional ability, from whom you will request letters of recommendation.

Name: _____

Title or position: _____

Address: _____

Telephone: (_____) _____ - _____

Name: _____

Title or position: _____

Address: _____

Telephone: (_____) _____ - _____

22. In addition to the required two passport photos 1 1/2" x 1 1/2" (print your full name on the reverse side of each), you must send two (2) letters of recommendation (which should be signed originals, on letterhead) and a copy of diploma from your medical school.

I certify that all the information supplied by me on this application is true and correct to the best of my knowledge. In the event that I have furnished any false information in this application, I understand and agree that I will be ineligible for the scholarship award and that I must return any money granted to me for such award. I have also enclosed the necessary letters of recommendation, and a check or money order for the **\$25** non-refundable processing fee.

Date

Signature

Print name here

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