WELSFORD AND MILDRED CLARK
MEDICAL MEMORIAL SCHOLARSHIP FUND

APPLICATION
Applications properly completed and signed should be returned to: Waterbury Medical
Association, One Regency Drive, P.O. Box 30, Bloomfield, CT 06002.

GENERAL INFORMATION AND ELIGIBILITY REQUIREMENTS
Scholarships are granted upon application to those students who seem best to satisfy
the requirements of the Welsford and Mildred Clark Medical Memorial Trust Fund in
the amount of up to $20,000 within the limits of the funds available. Review of
applications and the selection of winners have been assigned by the Trust Fund to the
Waterbury Medical Association.

The eligibility requirements for this scholarship award are:

1. Resident of Connecticut for five years. If you did not attend high school in
   Connecticut, please explain how you meet this requirement and state where
   you are registered to vote.
2. Third-year (M.D., D.O.) medical students (Scholarship Award to cover 4th year
   costs).
   (If student is graduating after 3 years, application must be received during
   the second year of medical school)
3. Enrollment in a not-for-profit medical school accredited by the AMA and/or
   the World Health Organization.
5. Academic excellence determined by a copy of the applicant’s transcript and
   the results of participation in Part I of the National Boards.
6. Extracurricular interests and community service.
7. Letters of recommendation from two faculty members and your Dean
   submitted directly to the Committee.
8. Statement of the applicant’s method of financial support during the previous
   years of medical school including a personal income statement of the
   applicant and spouse, if married.
9. A written statement concerning the applicant’s plan for his or her medical
   career.
Completed applications will be accepted through April 30 of the applicants third year in medical school. Winners will be announced on July 1 of the same year.

THE FOLLOWING QUESTIONS MUST BE ANSWERED BY ALL APPLICANTS
In order to judge your degree of need and your qualifications, the following specific information is required. So far as practicable, it will be regarded as confidential. In view of the facts set forth below, I hereby make application for financial aid for the year 20__ to 20__ in accordance with the conditions specified above which I have read.

Legal name in full ____________________________________________________________

Anticipated year of M.D. degree_____________________________________________

1. Local address for the coming school year:
   Street_______________________________________________________________
   City_________________________State/Zip_________Phone______________
   Home address:
   Street_______________________________________________________________
   City_________________________State/Zip_________Phone______________

2. Name & Address of High School__________________________________________
   Ranking in your graduating class_______________________________________

3. Premedical education (College or University): ____________________________
   Quality Point Average: _____________________________________________

4. Medical School: _______________________________________________________
   Name of Financial Aid Officer at Medical School__________________________

5. Father’s (or guardian’s) name in full____________________________________ Living____
6. Mother’s maiden name in full___________________________________________ Living____

7. Father’s occupation_____________________________________________________
8. Mother’s occupation___________________________________________________

9. Your date of birth (MM/DD/YYYY)_____________________________________

10. Country of birth_______________________________________________________

11. If foreign born, are you a naturalized citizen of the United States?__________

12. Please explain how you have been a legal resident of Connecticut for five years prior to applying. Where are you registered to vote?
    _______________________________________________________________________
    _______________________________________________________________________

1/2010
13. Total annual gross income of parents or trust funds

$______________ earned by _____ individuals.

(Note: No application will be considered unless this information is provided.)

14. Number of dependents supported wholly or in part from incomes stated under Question 13.______

15. Are you married? _______ Do you contribute to the support of others? ______

If so, explain circumstances.________________________________________________________

16. State below plans towards self-support for the coming year.__________________________

17. Please list any other scholarship awards or assistance you have received during medical school.________________________________________________________

18. Give as personal references the full names and addresses of two present members of your medical school faculty and the Dean. Please be sure all three letters are sent directly to the Committee.

19. Please list extracurricular interests and/or community service.________________________

20. Give details of present indebtedness? This may be included with personal finance statements. (see below) You must write the total amount of your indebtedness here.________________________

21. Please state in 150 words or less on an attached 8 1/2 x 11 sheet of paper, your plans for your medical career, including area of specialization, type of practice and location of practice.
22. Please include the following with this completed application.
   A. Medical school transcript
   B. Results of Part I of the Medical Boards
   C. Personal financial statement of applicant and spouse, if married
   D. Complete statement of medical school expenses – tuition, room, board, books, etc. for the first three years of medical school

CERTIFICATION
(1) I hereby certify that I will use the proceeds of the scholarship only for payment of tuition and required feed, room and board, the purchase of books, instruments and other necessary school supplies and equipment.
(2) I hereby acknowledge that the information submitted herewith is true and correct.

Signature ____________________________ Date ____________

For office use only

ACTION ON APPLICATION

1. Scholarship approved in the amount..........................$____________________
2. Scholarship denied - explanation:______________________________

______________________________
Date____________________

Waterbury Medical Association Official:

______________________________
Chairman, Selection Committee