

**HAMPSHIRE DISTRICT MEDICAL SOCIETY and THE ROLLIN M. JOHNSON, M.D.
SCHOLARSHIP APPLICATION**

MEDICAL STUDENT APPLICATION FOR EDUCATIONAL GRANT

[Please type or print]

Name:	<hr/>			
	First	Middle	Last	
Mailing Address:	<hr/>			
	Street	City	State	Zip
Legal Residence:	<hr/>			
	Street	City	State	Zip
Address (if different) in Western Massachusetts:	<hr/>			
	Street	City	Zip	
Phone:	<hr/>			
E-mail address:	<hr/>			

EDUCATION

Undergraduate School:

Full Name and Location	Graduation Year
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Graduate School [other than Medical School]:

Full Name and Location	Graduation Year
------------------------	-----------------

CERTIFICATION OF UNIVERSITY REGISTRATION

This is to certify that _____ has officially registered as a full-time student
in the _____ School of Medicine with the Class of _____.

Signature of Dean or Medical School Official

Date _____

CERTIFICATION OF MEDICAL SOCIETY MEMBERSHIP

This is to certify that I am currently a member of the Massachusetts Medical Society and the Hampshire District Medical Society.

Signature of Applicant

Date _____

The Hampshire District Medical Society offers this educational grant annually.

*Please submit applications to Hampshire District Medical Society, c/o Massachusetts Medical Society,
West Central Regional Office, 85 Post Office Park, Suite 8518, Wilbraham, MA 01095.*

APPLICATION DEADLINE: April 30, current year