HAMPSHIRE DISTRICT MEDICAL SOCIETY and THE ROLLIN M. JOHNSON, M.D.
SCHOLARSHIP APPLICATION
MEDICAL STUDENT APPLICATION FOR EDUCATIONAL GRANT

[Please type or print]

Name: _____
First Middle Last

Mailing Address: _____
Street City State Zip

Legal Residence: _____
Street City State Zip

Address (if different) in Western Massachusetts: _____
Street City Zip

Phone: _____

E-mail address: _____

EDUCATION

Undergraduate School: _____
Full Name and Location Graduation Year

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 _____.

_____ Date_____
Signature of Dean or Medical School Official

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.

_____ Date_____
Signature of Applicant

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

05/11/11