



# INDIANA UNIVERSITY SCHOOL OF MEDICINE



*Application for consideration and participation in the*

## Indiana Primary Care Scholarship Program

**2009-2010 Academic Year**

***Indiana University School of Medicine***

Office for Medical Student Affairs

VanNuys Medical Science Building, Room 119

635 Barnhill Drive

Indianapolis, IN 46202-5120

Tel. (317) 274-8568

Fax (317) 278-2691

**Section A: GENERAL INFORMATION**

Name (Last, First, M.I.) \_\_\_\_\_

Current Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

State of Residence \_\_\_\_\_

Effective Date of Residence \_\_\_\_\_

**Section B: COMMUNITY BACKGROUND**

In the following section, enter the four communities (if appropriate) in which you have lived the longest. Indicate the number of years you resided in each community, round this number to the nearest whole year. Include the community size by using one of the numbers below.

1. Small town (population less than 2,500)
2. Small city (2,500 to 20,000)
3. Medium-size city (20,000 to 50,000 including suburbs)
4. Large city (50,000 to 250,000 including suburbs)
5. Major metropolis (over 250,000 including suburbs)

**(OVER)**

**A.** \_\_\_\_\_  
Residence  
  
\_\_\_\_\_  
City, County, State  
  
Duration \_\_\_\_\_yr(s) Community Size \_\_\_\_\_

**B.** \_\_\_\_\_  
Residence  
  
\_\_\_\_\_  
City, County, State  
  
Duration \_\_\_\_\_yr(s) Community Size \_\_\_\_\_

**C.** \_\_\_\_\_  
Residence  
  
\_\_\_\_\_  
City, County, State  
  
Duration \_\_\_\_\_yr(s) Community Size \_\_\_\_\_

**D.** \_\_\_\_\_  
Residence  
  
\_\_\_\_\_  
City, County, State  
  
Duration \_\_\_\_\_yr(s) Community Size \_\_\_\_\_

**Section C: PRIMARY CARE COMMITMENT**

Enclose a personal statement that explains why you are choosing to enter a primary care specialty. Include any previous community service experience that has had an impact on your decision to become a primary care physician. Also include your professional goals and the special strengths you believe you may bring to a primary care specialty profession.

**The Selection Committee requires that the applicant provide at least two letters of recommendation.** One recommendation may be from a physician who knows of your interests and career goals. The second recommendation may be from someone who knows you well enough that also knows of your interest and career goals. Both recommendations should also address your relevant employment, commitment to primary care, community service, character skills, and involvement in serving others.

Have you applied or made a commitment to receive any funding that requires you to practice primary care in the state of Indiana or elsewhere?

**YES**  **NO**  If **YES**, address the funding source within your statement.

**Section D: CERTIFICATION STATEMENT**

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date