Butler County Medical Society

7249 Liberty Way Suite 200
West Chester, Ohio 45069
info@butlercountymedicalsociety.org

Scholarship Application

*Note: All information provided on this application is **CONFIDENTIAL.***

Name_____ Date of Birth _____

Street_____

City, State, Zip Code_____

Preferred contact #_____ E-Mail _____

Social Security # _____ Marital Status_____

High School _____ Year Graduated_____

College_____ Year Graduated_____

Medical School_____ Anticipated graduation year _____

Father or Male Guardian_____ Age_____

Street_____

City, State, Zip Code_____

Mother or Female Guardian_____ Age_____

Street_____

City, State, Zip Code_____

Siblings_____ # in College_____ # Dependents on guardian's tax return_____

Applicant's annual income_____

Amount of financial aid you receive from your parents_____

Spouse_____ Annual Income_____

Employer_____ Current Position_____

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List any additional sources of income, i.e. loans, grants, scholarships:

Source Amount

_____

_____

_____

_____

Have you considered practicing in Butler County upon completion of your education? _____

List any involvement or community service you and your family have had in Butler County, beginning with your high school years:

Please attach a one page summary of why you think this scholarship should be given to you.

Provide two (2) letters of reference including one letter from your school's dean of student affairs.

The deadline for this application is June 30th of the current year. Scholarships are granted in July. You may apply annually for scholarships. Please email all scholarship application documents to info@butlercountymedicalsociety.org.

I certify that all the information provided for this application is correct.

Signature_____ Date_____