Hartford County Medical Association, Inc.
250 Wolcott Road, Suite 3
Wolcott, CT 06716
(T) 203-441-6142 (F) 860-955-2419 www.hcma.org

Application Deadline:
August 1, 2019

HARTFORD COUNTY MEDICAL FOUNDATION, INC. SCHOLARSHIP APPLICATION

NAME____ SEX: ____M ____F

MAILING ADDRESS______________________________________ BIRTHDATE: _________

CITY_____________________STATE______ ZIP________ PHONE____________

PERMANENT ADDRESS______________________________________
(if different)
CITY_____________________STATE______ ZIP_________ PHONE____________

SCHOOL ____ DEGREE SOUGHT OR PROGRAM OF STUDY _______________

ADDRESS ____

CITY_______________________________STATE______ ZIP _________ YEAR OF STUDY 1 2 3 4 5

SCHOOL CONTACT ____

COLLEGE GRADUATED FROM __________________________ YEAR ______DEGREE _________ MAJOR _________

HIGH SCHOOL ____ YEAR GRADUATED ____________

ARE YOU CURRENTLY EMPLOYED ____Y ___N

EMPLOYER ____ SUPERVISOR __________________

MAILING ADDRESS ____HOURS PER WEEK _____________

CITY__________________ STATE______ ZIP________ PHONE____________

I am currently a resident of Hartford County: ____Y ____ N
I was a resident of Hartford County prior to entering high education: ____ Y ____ N
If yes, please provide former address: ____

THE FOLLOWING INFORMATION MUST ACCOMPANY THE COMPLETED APPLICATION FOR CONSIDERATION

1. Letters of recommendation from two people not related to you. One should be from a faculty member or administrator at a school you attend or have attended.
2. Certified school transcript (s) of the last 2 years of study.
3. A brief essay about your long-range career goals.

All information I have presented as part of this application is true to the best of my knowledge.
I authorize the Hartford County Medical Foundation, Inc. to verify the information provided in this application.
I understand that if I do not complete the year of education for which the scholarship is awarded, I will refund all or part of the payment to the scholarship fund.

Signature ____ Date ____________________