



The Dr. William Jones Mc Elhiney Medical School Scholarship Application

Presented by:
St. Charles – Lincoln County Medical Society
&
Missouri State Medical Association
(the application can be found and completed at www.sclcms.net)

Name _____

Home Address: _____

_____ City State Zipcode

Applicant's Phone Number _____

Applicant's Email Address _____

Parents' Name _____

Expected year of graduation from medical school _____

Missouri Medical School _____

School Address _____

_____ City State Zip Code

St. Charles-Lincoln County High School you attended _____

College Education _____

Year of Graduation from College _____ Major _____ Grade Point Average _____

Place of Birth _____

US Citizenship? [] Yes [] No If not a US citizen, are you a permanent resident? [] Yes [] No

What is your anticipated field of practice in Medicine? _____

Honors, awards, significant achievements from high school, college and/or medical school _____

Your work history, including summer jobs, volunteerism, etc. _____

Community Involvement _____

Father's occupation _____ Annual Income _____

Mother's occupation _____ Annual Income _____

Sibling(s) _____
Number of sibling(s) in college, professional or graduate school _____

Do you plan to practice medicine in St. Charles or Lincoln County? Yes No
Do you plan to practice medicine in the State of Missouri: Yes No
Do you belong to the student MSMA or AMA? Yes No

Professional References (Please provide two – please give name, address and contact telephone number)

Reference #1

Reference #2

Are you married Yes No OR plan to marry during the current academic year: Yes No ___
Date of pending marriage _____

What is the value of assets owned by you and/or spouse?

Savings Account \$ _____ Stocks & Bonds \$ _____ Real Estate Equity \$ _____
Trust Fund(s) \$ _____ Other (provide complete information on a separate sheet and attach to application)
Total Assets \$ _____

What is the value of your current debt?

Consumer debt - Applicant \$ _____ Spouse \$ _____
Education debt - Applicant \$ _____ Spouse \$ _____
Other debt (please explain) Applicant \$ _____ Spouse \$ _____
What is the year of the automobile you drive? _____ Make of auto _____ Model _____
Unpaid balance of auto loan \$ _____ Monthly payment \$ _____

How much financial assistance do you expect to receive this year from your parents? _____

From other relatives, friends? _____

How much \$? _____

Source? _____

I hereby permit the St. Charles – Lincoln County Medical Society to use biographical, academic and financial information contained in this application to determine a possible award for which other students are also applying.

I declare and certify that the information on this document is complete and correct.

Signature

Date

Or

I accept these terms (if completing application electronically) Date _____
 I decline these terms (if completing application electronically) Date _____

**Return your completed Scholarship Application
No later than
November 3, 2024**

**Mail to:
Martin L. Willman, MD
2304 Todforth Way
Saint Louis MO, 63131
*or***

**Email to:
willmanm@gmail.com**