The Madison County Medical Alliance (MCMA) is pleased to announce the availability of applications for its MCMA UAB-Huntsville Medical Student Award.

Eligibility:
- Applicant must be a United States Citizen
- Applicant must be a resident of Alabama
- Applicant must be a fourth-year medical student at UAB-Huntsville campus when applying.
- Applicant must be staying in the state of Alabama for his/her residency program

Applicant must submit the following:
1. A completed application form
2. One reference letter (non-family member)
3. A letter on school letterhead, from the applicant’s medical school verifying that he/she is enrolled full time as a fourth-year medical student.
4. A typed Curriculum Vitae (Resume)
5. A picture
6. A typed essay, one page, must be submitted describing the applicant’s vision for the future of medicine in Alabama.

Deadline and Notifications:
Application materials will be accepted beginning February 1 (if you participated in early match programs) or after Match Day of the current year and must be postmarked by April 15 of the current year. Applications may be emailed to madisoncountymedicalalliance@gmail.com (preferred) or mailed to Madison County Medical Alliance PO Box 2386, Huntsville, AL, 35804.

Applicants will be notified of the committee’s decision by May 1 of the current year

If you have any questions, please email madisoncountymedicalalliance@gmail.com

Award Details:
The award is intended to provide financial support to offset the transition to residency for those committed to patient care in the State of Alabama.
1st Place $1500
2nd Place $1000

Presentation:
The MCMA UAB-Huntsville Medical Student Award will be presented at the Awards/Graduation dinner for UAB-Huntsville Medical School.
Madison County Medical Alliance
UAB-Huntsville Medical School Award

APPLICATION FORM

PERSONAL INFORMATION (Please type or print clearly)

Name__________________________________________________________

Address________________________________________ City________ Zip_____

County of Legal/permanent address:_____________________________________

Date of Birth___________________________

Phone____________________________(cell)________________________

Email__________________________________________________________________

Driver’s License Number________________________DL State______________

FAMILY INFORMATION

Spouse Name_____________________________________________________

Spouse Occupation_______________________________________________

Number of children/dependents (other than spouse)___________________

SCHOOL/RESIDENCY INFORMATION

Name of residency program at which you have been accepted:

Field of Medicine_________________________________________________

How many years is your chosen residency program?____________________

FINANCIAL INFORMATION

Did you receive scholarships and/or grants in medical school?___________

Did you receive financial assistance from your parents, other relatives or friends during medical school?______________________________

Will you receive any untaxed income and/or benefits (i.e. child support, Social Security benefits, welfare, etc) during the current residency year?________
FINANCIAL WORKSHEET:
Non-Profits are required to gain financial information when giving a monetary award or scholarship.

Your Education Debt:
Undergraduate School $_______________________________
Graduate School $_______________________________
Medical School (amount to date) $_______________________________
Other (please specify)
$_______________________________ $_______________________________
$_______________________________ $_______________________________
Total Educational Debt $_______________________________

You and your spouse’s debt:
Automobile loan(s) $_______________________________
Credit Cards $_______________________________
Personal Loans $_______________________________
Other:____________________________ $_______________________________
Total Debt: $_______________________________

SOURCES OF INCOME
Previous Tax Year Income Earned from Work (You) $_______________________________
Previous Tax Year Income Earned from Work (Spouse) $_______________________________
Total Income from Work $_______________________________
MCMA UAB-Huntsville Medical Award

Applicant Name______________________________

PLEASE READ, SIGN AND DATE

My signature certifies that I have read, understand and agree to the terms and conditions of this application and that all information provided on this application is correct. I also understand that said information is regarded as confidential and for the exclusive use of the MCMA Scholarship Committee for the purpose of determining scholarship awards.

The undersigned also agrees to waive all personal claims, causes of action, or damages against the Madison County Medical Alliance, its board members, officers, and associates thereof, arising from or growing out of their participation in the MCMA Award program. In addition, the undersigned agrees to allow his/her name and essay to be used for publicity purposes should he/she be awarded the award.

Student Signature____________________________________Date____________________