

MADISON COUNTY  

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**MEDICAL  
ALLIANCE**  
Building Healthy Communities

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's marital status must be "married"

**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 March 1 of the current year and must be postmarked by May 1 of the current year. Applications should be mailed to MCMA, PO Box 2386 Huntsville, Alabama 35804.

Applicants will be notified of the committee's decision by June 1 of the current year.

If you have any questions, please email [madisoncountymedicalalliance@gmail.com](mailto:madisoncountymedicalalliance@gmail.com)

**Award Details:**

The award will be of monetary value to aid the graduating medical student and his/her family.

**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?\_\_\_\_\_

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### **MCMA UAB-Huntsville Medical Award**

**Applicant Name**\_\_\_\_\_

### **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**    \$ \_\_\_\_\_

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### **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 \_\_\_\_\_