

**ASPEN VALLEY HOSPITAL MEDICAL STAFF  
MEDICAL SCHOOL SCHOLARSHIP 2010**

**ABOUT THE SCHOLARSHIP FUND**

The Aspen Valley Hospital Medical Staff Medical School Scholarship Fund is made possible by funds donated by Aspen Valley Hospital physicians. The Aspen Valley Medical Staff offers this scholarship for assistance with medical school.

**ELIGIBILITY REQUIREMENTS**

1. Graduates of Aspen and Basalt High Schools. You do not have to be a current resident to apply.
2. Enrolled in an accredited American medical school on a full-time basis (12 units or more).

**EVALUATION PROCEDURES**

The amount of scholarship funds awarded will be determined by the Aspen Valley Medical Staff Scholarship Committee (CME Committee), who will review all applications and make the final decision.

Applications will be evaluated on:

1. 2 letters of recommendation – 1 letter should be from a Professor with which the applicant has studied.
2. An essay with what the applicant's goals and aspirations in the Medical field.

**HOW TO APPLY**

1. The entire application must be completed in full and typewritten. Feel free to scan the attached application into your own word processing program or retype the entire application form. However, the format we've outlined may not be altered.
2. Scholarship requests for reimbursement funding for retroactive courses will NOT be considered.
3. **DEADLINE:** The application must be postmarked or e-mailed by **June 1** of your medical school application year. Any application received after the deadline will not be considered. Applications may be submitted to:  
Aspen Valley Hospital CME Committee  
401 Castle Creek Road, Aspen, CO 81611  
ATTN: Nancy Arnold, Continuing Medical Education Committee.

Applications may also be submitted in person directly to Nancy Arnold at Aspen Valley Hospital.

**GRANT CYCLE**

The applications will be reviewed and a decision will be made by **September 1**. The applicant(s) will be notified at that time.



**IV AUTHORIZATION AND CERTIFICATION**

I certify that all of the information submitted with my application is true and complete to the best of my knowledge. If asked by an authorized official of the Aspen Valley Hospital Scholarship Committee, I agree to provide proof of the information I have given. I understand that the inclusion of any false or misleading information will result in the rejection of my application or the return of any financial aid I do receive.

Permission is hereby given to school, federal, state and/or county officials to release to the Aspen Valley Hospital Scholarship Committee any information concerning academic circumstances necessary to my application for a grant from the Aspen Valley Hospital Medical Staff Medical School Scholarship fund. I also agree to permit Aspen Valley Hospital Scholarship Committee to share the information I have provided with any of the references I have listed.

I understand that in order for my request to be considered for September funding, my application, references and official transcripts must be received by the Aspen Valley Hospital Scholarship Committee no later than June 1. Furthermore, I have read the application instructions, and I am aware that an incomplete application will not be processed.

\_\_\_\_\_  
APPLICANT Signature

\_\_\_\_\_  
Date

**I AUTHORIZE THE ASPEN VALLEY HOSPITAL MEDICAL SCHOLARSHIP COMMITTEE TO CONTACT ANY AND ALL LISTED BELOW FOR A CONFIDENTIAL REFERENCE:**

Employment Reference _____	Phone: _____
_____	Phone: _____
Educational Reference _____	Phone: _____
_____	Phone: _____
Personal Reference _____	Phone: _____
Medical School Reference _____	Phone: _____

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date