

Roanoke Academy of Medicine Alliance Foundation (RAMA)
Scholarship Committee
P.O. Box 8602
Roanoke, VA 24014

SCHOLARSHIP APPLICATION
HEALTH RELATED PROFESSIONS

Instructions: Read and answer every question. Please print or type all information. **No applications will be considered unless all questions are answered and all facts are disclosed.** This is an annual award and applicants must submit a new application form to the RAMA Scholarship Committee each year. The recipient will be responsible for determining if any portion of the scholarship is subject to income tax.

Each recipient of a RAMA scholarship must execute an agreement to repay to RAMA all scholarship funds in the event that he/she does not complete the school year for which the funds were received.

This application must be postmarked no later than **April 25, 2017**. **Any applications postmarked after that date will not be considered.**

PLEASE RETURN TO: Roanoke Academy of Medicine Alliance Foundation
 P.O. Box 8602
 Roanoke, VA 24014
 Attn: Scholarship Committee

To be considered, the Scholarship Committee must receive a COMPLETE APPLICATION PACKET by the date indicated. Any application received with a postmark later than April 25, 2017 will not be considered.

A complete packet consists of the following:

1. Completed application, including essay.
2. A copy of the 1040 tax form of person responsible for financial support.
3. Three letters of reference, one of which must be from a current teacher or faculty member in an academic subject. Letters must be included in the application_packet.
4. Authorization for release of record information (page # 6).
5. Official transcript from current school or last school attended. Late transcripts will make applicant ineligible.
6. Financial aid officer form (page #7) completed and signed.

ROANOKE ACADEMY OF MEDICINE ALLIANCE FOUNDATION
SCHOLARSHIP COMMITTEE
P.O. BOX 8602
ROANOKE, VA 24014

SCHOLARSHIP APPLICATION

Check one: _____ Applied for _____ Enrolled in
School: _____
Program: _____
Year of Program: _____

PERSONAL DATA:

Name: _____ Birth Date: _____
 Last First Middle
Address: _____ SS#: _____
 Street
 City State Zip Phone #: _____
Marital Status: _____ Email: _____

EDUCATIONAL HISTORY:

Name	Dates Attended	Degree	GPA
High School: _____			
Post Graduate: _____			

EMPLOYMENT HISTORY: List your two most recent positions.

_____	_____
Place Employed	Address
_____	_____
Position	Dates Employed
Contact person: _____	Phone #: _____

_____	_____
Place Employed	Address
_____	_____
Position	Dates Employed
Contact person: _____	Phone #: _____

Will you continue to work while attending school? _____ Yes _____ No

FINANCIAL DATA:

Please check main source of financial support:

Parent _____ % Spouse _____ % Self _____ % Other _____ %

Complete the following information for all sources of financial support:

Name: _____ Relationship: _____
Address: _____ Occupation: _____
Annual Income: _____
Number of other dependents _____
and their ages _____

Name: _____ Relationship: _____
Address: _____ Occupation: _____
Annual Income: _____
Number of other dependents _____ Ages of dependents _____

Do you participate in an exchange of tuition for employment with a medical institution?
Yes _____ No _____
If so, please provide details _____

Have you received a RAMA Scholarship before? _____
If so, for which academic year? _____
Amount received \$ _____

FINANCIAL AID WORKSHEET

Please check appropriate blank:

1. Will you be registered as full time _____ or part time _____?
2. Will you live "on campus" _____ or "off campus" _____?

LIVING EXPENSES: Please list annual cost where applicable:

Room and Board and/or Rent	\$ _____
Personal/Food	_____
Utilities	_____
Insurance	_____
Other: Please list, i.e., child care, car, transportation, etc.	_____
TOTAL # 1	\$ _____

ESTIMATED EDUCATIONAL EXPENSES: Please list annual cost:

Tuition	\$ _____
Books and Supplies	_____
TOTAL # 2	\$ _____

ESTIMATED INCOME: Please list source and amount per year you receive from parents, spouse, self, other, etc.

_____	\$ _____
_____	_____
_____	_____
TOTAL # 3	\$ _____

OTHER SCHOLARSHIP AID APPLIED FOR AND/OR RECEIVED FOR THE UPCOMING ACADEMIC YEAR: Please list grants and/or awards applied for, whether received at this time, and the amount of the award. Please use an additional sheet of paper if necessary.

<u>Title of Scholarship/Grant</u>	<u>Amount Applied For</u>	<u>Status of Grant (Pending or Received)</u>	<u>Amount Received</u>
_____	\$ _____	_____	\$ _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL # 4			\$ _____

SUMMARY FROM ABOVE INFORMATION:

<u>TOTAL EXPENSES</u>		<u>TOTAL INCOME</u>	
Cost of living total (#1)	_____	Estimated income (#3)	_____
Educational expenses (#2)	_____	Awards/Grants received (#4)	_____
Total Expenses	\$ _____	Total Income	\$ _____

PERSONAL SUMMARY:

Please explain why you chose this field and why you need assistance from this scholarship fund. Include any unusual circumstances which relate to your need for financial assistance, and any information you consider important for the Scholarship Committee to consider. **ATTACH A SEPARATE 8 X 11 SHEET OF PAPER CONTAINING YOUR PERSONAL SUMMARY.**

ATTESTATION

I certify that all information submitted in this scholarship application, including the application, the financial aid worksheet, the personal summary, and all documents submitted in support of this application, is true, correct, and honestly presented. I understand that in the event that I have misrepresented any of the information submitted in this scholarship application I may be required to repay the full amount of any scholarship awarded.

Signature of Applicant

Date

Printed Name of Applicant

ROANOKE ACADEMY OF MEDICINE ALLIANCE FOUNDATION
SCHOLARSHIP COMMITTEE
P.O. BOX 8602
ROANOKE, VA 24014

AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORD INFORMATION
Must be postmarked by April 25, 2017

Name: Last	First	Middle	Maiden
Street Address	City	State	Zip
Telephone Number	Date of Birth	Social Security Number	
Current/Last School Attended	Date Graduated/Withdrew (if applicable)		

_____ is hereby authorized to release or
Name of Academic Institution
exchange the following specified information with the RAMA Scholarship Committee.

INFORMATION OR RECORDS

_____ Official Scholastic Record (name, address, birth date, grade level completed, grades, class standing, attendance record, standardized achievement test scores, school, community activities, work experience)

The reason for this disclosure is _____

_____ Date _____ Parent's/Guardian's/ Eligible Student's Signature

Return information by
April 25, 2016 to:
,
Roanoke Academy of Medicine Alliance Foundation
Scholarship Committee
P.O. Box 8602
Roanoke, VA. 24014

ROANOKE ACADEMY OF MEDICINE ALLIANCE FOUNDATION
SCHOLARSHIP COMMITTEE

Date: _____

School: _____

Program student is
accepted into: _____

Entering Academic Year: 1 2 3 4
(circle correct number)

Anticipated Graduation Date: _____

Must be completed and signed by the financial aid officer at the school the applicant will attend and mailed with the entire scholarship application packet by April 25, 2017, as described on page 1.

Name of applicant: _____

Father _____ Occupation _____

Mother _____ Occupation _____

Spouse _____ Occupation _____

Annual income of parents or spouse _____

Additional sources of income _____

Assistance received (amount) _____

Has the student received a RAMA scholarship before? Yes No

If Yes, what academic year? _____

Are you aware of any special circumstances that may affect student's income?

Yes No

If so, please explain.

Summary of financial need and recommendations:

Signed: _____ Date: _____

Title: _____

Failure to fully complete this form may disqualify applicant.