STATE MEDICAL EDUCATION BOARD OF GEORGIA

All Scholarship Applicants:

Enclosed are application materials for the State Medical Education Board Scholarship Program. The scholarship amount for the 2010-2011 academic year will be up to $20,000. Pending the availability of funding, scholarships may be renewed, on an annual basis, three times, providing qualified applicants with up to four scholarships.

The enclosed information includes materials describing the requirements of the program. Please note that by obtaining a scholarship you agree to practice medicine full-time (a minimum of 40 hours per week) in a Board-approved Georgia county having a population of 35,000 or fewer people according to the U. S. Census Count of 2000. You may also practice full-time, a minimum of 40 hours per week, at any facility operated under the jurisdiction of the Georgia Department of Community Health, Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Department of Corrections or the Georgia Department of Juvenile Justice at the conclusion of your medical training.

In order for your application to be considered by the Board, you must submit **all** the following documents postmarked or hand delivered by **June 1, 2010**:

1. Completed Application Form (include a recent black and white photo)
2. Completed Certification of Residency Form (form enclosed)
3. Letter of acceptance to an accredited medical school (If you have not yet been accepted, submit all other application documents pending your acceptance)
4. Completed Applicant Financial Information Forms (forms enclosed)
   *Applicants wishing to display substantial financial hardship should include a copy of his or her Student Aid Report (SAR), the official summary of the Free Application for Federal Student Aid (FAFSA)
5. Copy of most recent 1040 or 1040EZ Forms (or other applicable tax forms)
6. Copy of the personal statement from your medical school application
7. Transcript of your grades if currently enrolled in medical school
8. Selective Service Information for all male applicants (form enclosed)
9. Authorization and Release Form (form enclosed)

After receipt of all application materials, all scholarship applicants will be **required** to attend a formal interview with the members of the Board in July.

If you desire additional information or assistance with your application, please write or call this office at (404) 206-5420.

Sincerely,

Cherri Tucker
Executive Director

Enclosures

The State Medical Education Board of Georgia

Scholarship Program

Academic Year 2010-2011

Applicant Information Bulletin

This document describes the State Medical Education Board of Georgia Scholarship Program. Program participants will be bound by contract to adhere to the provisions outlined in this document.

Please keep this Bulletin for future reference.

STATE MEDICAL EDUCATION BOARD OF GEORGIA
SCHOLARSHIP PROGRAM

PURPOSE OF THE PROGRAM

The State Medical Education Board Scholarship Program was created in 1952 to provide a supply of physicians for rural areas of the State and to help defray the cost of medical school for Georgia residents who desire to practice medicine in rural Georgia. The service repayable scholarship will provide up to $20,000 per year to help pay the cost of medical school in return for a contractual obligation to practice medicine full-time (a minimum of 40 hours per week) in a Board-approved Georgia county with a population of 35,000 or fewer persons.

ELIGIBLE APPLICANTS

All applicants must be legal residents of the State of Georgia and citizens of the United States. In order for an application to be considered by the Board, the applicant must be accepted into an L.C.M.E. or A.O.A. accredited four-year medical school located in the United States offering the degrees of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). All scholarship recipients must pursue a course of study that will allow them to qualify for licensure by the Georgia Composite Medical Board.

Successful applicants must exhibit a strong commitment to practice medicine in rural Georgia (a Board-approved Georgia county having a population of 35,000 or fewer persons). Additional priority will be given to those applicants who demonstrate financial need. The applicant is required to disclose his/her own financial information.

Applicants who currently hold other service obligations are not eligible to apply.

APPLICATION REQUIREMENTS

1. Completed application form (form provided)
2. Completed Certificate of Residency (form provided)
3. Male applicants are required to submit evidence of having registered for Selective Service (form provided)
4. Financial information as to the inability of the applicant to finance his or her medical education (forms provided)
   * Applicants wishing to display substantial financial hardship should include a copy of his or her Student Aid Report (SAR), the official summary of the Free Application for Federal Student Aid (FAFSA)
5. Copy of most recent 1040 or 1040EZ Forms (or other applicable tax forms)
6. Letter of acceptance to an accredited medical school
7. Copy of personal statement from medical school application
8. Completed Authorization and Release Form (form provided)
9. Attend the formal applicant interviews conducted by the Board at the July meeting

The Board is charged with receiving and acting upon all applications for scholarships made by students who are residents of Georgia who desire to become doctors and who make a contractual commitment to practice medicine full-time in an approved Georgia community.

FINANCIAL HARDSHIP

Applicants wishing to display a substantial financial hardship should submit a copy of his or her Student Aid Report (SAR), the official summary of the Free Application for Federal Student Aid (FAFSA). This report will be used by the board in assessing the financial need of the applicant outside of the SMEB provided financial forms. Applicants need only include this report if he or she would like to demonstrate substantial financial need for scholarship funding.

CONTRACTUAL OBLIGATIONS

All scholarship recipients are required to sign a contract with the State Medical Education Board agreeing to the terms and conditions upon which the scholarships are granted. This contract establishes the amount of the scholarship award, the date of the contract and the corresponding census count used to determine eligible practice locations, as well as the terms and conditions of program participation pertaining to medical training, obligated service and the conditions of default and cash repayment.

For each year of full-time medical practice in a Board-approved Georgia county having a population of 35,000 or fewer persons, or at any hospital or facility operated under the jurisdiction of the Georgia Department of Community Health, Georgia Department of Behavioral Health and Developmental Disabilities, the Georgia Department of Corrections or the Georgia Department of Juvenile Justice, the recipient will receive credit for the amount of scholarship funds which he or she received during any one year in medical school. The authority for county populations is the Decennial Census Count of the United States Bureau of the Census effective at the time the scholarship contract is signed.

AWARDING AND FUNDING OF SCHOLARSHIPS

Scholarship funding is based upon the amount of funds appropriated to the State Medical Education Board by the Georgia General Assembly. The funding amount for scholarship awards during the 2010-2011 academic year will be up to $20,000 each. Upon the submission of a signed contract and verification that the student is enrolled in the medical school named in said contract, scholarship funding is authorized. Scholarship funds are disbursed directly to the medical school to address yearly tuition and fees with any remaining funds being disbursed to the student by his/her medical school.

CONTRACT RENEWAL

The contract term is one year. Contracts may be renewed for additional one-year term for a maximum of four years. Each scholarship recipient is required to complete and submit an annual report to the Board concerning their status in training.
The Annual Report includes:

A. All current and valid contact information
B. Medical school enrollment status and verification of good academic standing
C. Date of graduation
D. Plans for specialization
E. Continued interest and recommitment to rural practice

SCHOLARSHIP REPAYMENT OBLIGATIONS

Each recipient is required to obtain Board approval of any proposed practice location. Credit for practice repayment is applied one year of funding for each year of service rendered in compliance with the repayment provisions of the scholarship contract. Practice without written Board approval will not be credited toward the satisfaction of the contractual service obligation.

The recipient must practice full-time, a minimum of forty hours per week, in the Board-approved practice location. If a recipient changes practice location for any reason, he/she must request Board approval of any subsequent practice location.

STUDENTS DISMISSED OR WITHDRAWN

In the event a scholarship recipient is dismissed from medical school for either academic or disciplinary reasons, or a recipient voluntarily withdraws from medical school, the scholarship recipient is immediately liable for all scholarship funds received, plus accrued interest at the rate stated in the scholarship contract.

CONTRACT DEFAULT

A scholarship recipient will be considered in default under the following circumstances:

A. Failure to keep the Board informed of current contact information (phone, address, etc.)
B. Failure to submit reports, forms, transcripts, etc., as required by the Board
C. Failure to obtain Board approval of practice location
D. Failure to begin or complete approved practice obligation
E. Failure to maintain a full-time (minimum of forty hours per week) medical practice
F. Failure to obtain and maintain a valid medical license from the Georgia Composite Medical Board

In the event the State Medical Education Board finds a scholarship recipient in default, the recipient is immediately liable for triple the principal amount of scholarship funds received.

PRACTICE LOCATION ASSISTANCE

In cooperation with other interested organizations and rural Georgia communities, the State Medical Education Board sponsors an annual Medical Fair. This function is designed to enable physicians to meet representatives from 35-40 qualifying rural Georgia communities to discuss practice opportunities in our State.

The Georgia Board for Physician Workforce maintains information pertaining to practice opportunities statewide. Many of these opportunities are rural locations eligible for repayment of the scholarship obligation. In addition, the staff of the State Medical Education Board, through contact with scholarship recipients in practice and rural Georgia communities, will provide information pertaining to practice opportunities from time to time. However, each scholarship recipient is responsible for securing a qualifying practice location for themselves. The SMEB IS NOT responsible for locating a suitable practice site for recipients.

OBTAINING AN APPLICATION

Applications are available from the State Medical Education Board at any time by phone request, on the website, www.smeb.georgia.gov, or by email SMEB at smeb@dch.ga.gov. Completed applications should be received in the State Medical Education Board office no later than June 1, 2010 for consideration.

For applications or additional information, please contact:

State Medical Education Board of Georgia
Scholarship Program
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496
Telephone: 404-206-5420
Fax: 404-206-5428
Email: smeb@dch.ga.gov
Website: www.smeb.georgia.gov

Attach recent photo, preferably with a light background. Attach with paper clip ONLY!!

APPLICATION

State Medical Education Board Scholarship Program

State Medical Education Board of Georgia
1718 Peachtree Street, NW. Suite 683
Atlanta, Georgia 30309-2496
Telephone: 404-206-5420
Fax: 404-206-5428

Please print or type legibly

PERSONAL HISTORY:

Full Legal Name:_____
Last First Middle/Maiden

SSN: _____/_____/_____ Birthdate: _____/_____/_____ Race: _____ Sex: _____

Permanent Mailing Address:_____
Street/Apt/Box No. City State Zip

Current Mailing Address: _____
Street/Apt/Box No. City State Zip

Date this address will change: _____ Current Daytime Phone: _____

Email Address: _____

Birthplace: City _____ County _____ State _____

Hometown in Georgia: _____ Age: _____ Number of Years You Have Resided in Georgia: _____

List other places of residence and the number of years in each place: _____

_____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Name of Spouse: _____ Spouse's Hometown: _____

Name of contact person who will always know your whereabouts:

Full Name _____ Relationship to Applicant _____

Address: _____
Street/Apt/Box No. City State Zip Phone

EDUCATIONAL HISTORY

School	Name, City/State	Year Entered	Year Graduated	Diploma/Degree
High School				
College				

SAT Score: _____ or ACT Score: _____

MCAT Scores: Biological Science _____ Physical Science _____ Verbal Reasoning _____ Writing _____

GPA: Last Academic Year: _____ Overall GPA: College _____ Medical School _____

Medical School You Plan to Attend: _____

If presently enrolled, please check class rising: Second Year _____ Third Year _____ Fourth Year _____

Offices and Honors: _____

_____

_____

EMPLOYMENT HISTORY

If you worked while in school during afternoons, weekends, holidays, summers, etc., give detailed information as requested:

Year	Place of Employment	Duties	Length of Employment	Total Earnings
(HIGH SCHOOL)				
Fr.				
Soph.				
Jr.				
Sr.				
(COLLEGE)				
Fr.				
Soph.				
Jr.				
Sr.				
(PRESENT EMPLOYMENT)				

Indicate How Your College and Medical School Expenses Have Been Paid:

	College	Medical School
Paid by Earnings	_____%	_____%
Paid by Parents	_____%	_____%
Paid by Scholarships	_____%	_____%
Paid by Loans	_____%	_____%
Other Sources, Please list:		
_____	_____%	_____%
_____	_____%	_____%
	100%	100%

Total Present Educational Indebtedness: $ _____ (should agree with loan amount above)

List Scholarships Received by Year, Amount and Institution: _____

_____

Are any of these scholarships service cancellable? Yes No If so, which? _____
**SMEB Scholarship recipients cannot hold other service cancellable scholarships or loans.*

Other Sources of Income (if any): _____ Amount: $ _____

Amount Spouse Contributes to Your Medical Education: $ _____

The foregoing information is true and correct to the best of my knowledge and belief. I understand that if I receive and accept a State Medical Education Board Scholarship, I will be required to practice medicine on a full-time basis in a Board-approved county of 35,000 population or less, according to the U. S. Census Count of 2000, or a position with the Georgia Departments of Juvenile Justice, Corrections, Community Health or Behavioral Health and Developmental Disabilities. For each year of practicing my profession in such location, I will receive credit for the amount of scholarship I received during one year of medical school. I further understand that my residency program must be approved by the Board.

_____ _____
Signature of Applicant Date

Official Notary:
I hereby certify that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, _____ (applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledged before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of _____, County of _____ and State of _____,

this _____ day of _____, 20___.

_____ My commission expires: _____
Notary Signature (Affix Seal)

PRACTICE PREFERENCES

Please list 3 Georgia counties in which you are interested in practicing. Your choices are limited to counties having a population of 35,000 or fewer persons, or positions with Georgia Departments of Corrections, Community Health, Behavioral Health and Developmental Disabilities, or Juvenile Justice.

_____

_____

_____

REMARKS: Information not requested in the application that you feel may be pertinent to your application.

_____

_____

_____

_____

_____

_____

_____

_____

STATE MEDICAL EDUCATION BOARD OF GEORGIA
1718 Peachtree St., NW, Suite 683
Atlanta, Georgia 30309-2496

CERTIFICATION OF RESIDENCY

Full Name _____

Sex _____ Date of Birth _____ Place of Birth _____

Temporary Address _____

Telephone Number ( ) _____ Social Security # _____

Permanent Home Address _____

Parents Address _____

If Married, Name of Spouse _____

Current Address of Spouse _____

Medical School You Are Planning to Attend _____

Present College Enrollment _____

Georgia Residency Maintained Continuously Since (Year)_____ (Month) _____

High School Attended _____

Most Recent Driver's License Issued by Which State _____

Automobile(s) (If Any) Registered in Which State _____

Year and State for Which Last State Income Tax Return was Filed _____

State of Residence Claimed on Last State/Federal Income Tax Return _____

This Residence was Claimed for Whole or Part Year _____

In Which State Were You Last Registered to Vote _____ Date _____

The above information is given to the official whose signature appears below for the purpose of assisting the said official in determining my legal residency status.

Sworn to and subscribed before me this_____ day of _____, 20___.

_____ _____
Notary Public Signature Applicant Signature

Notary
Affix Seal Here

CERTIFICATION OF RESIDENCY

*<u>The Following Certification Must be Executed by the Clerk of Court of the County Where You Maintain Your Legal Residence</u>.

Based on the above information, I hereby Certify that, in my opinion, _____ _____ is and has been a legal resident of the County of _____ and the State of _____ for the past twelve (12) months or more.

Signature of Official _____

Title _____ Date _____

STATE MEDICAL EDUCATION BOARD OF GEORGIA
Scholarship Application

APPLICANT FINANCIAL INFORMATION

All information provided will remain confidential

Please respond to every question, using n/a or "0" if necessary. Please type or print legibly.

1. Full Name _____

2. Permanent Mailing Address _____
Street Apt. Number E-mail Address

_____
City State Zip Area Code/Telephone Number

3. State of Legal Residence _____

4. List the number of years (in each city) you have resided in Georgia (i.e., 18, Atlanta; 5, Rome) _____

_____

List all other states in which you have resided, along with the number of years (i.e., 4, Ohio) _____

_____

5. Citizenship: _____ U.S. Citizen _____ Resident Alien _____ Other, please specify _____

6. Sex: _____ Male _____ Female

7. Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

8 . Will you have received your undergraduate degree by July 1, 2010? _____

List your undergraduate field of study _____

9. Expected degree (M.D./D.O.) _____ Expected date of graduation _____

10. Did you live with your parents during all or part of 2009? _____

11. Did your parents claim you as a tax exemption during 2009? _____

12. Did you receive more than $750 support from your parents during 2009? _____

13. The total size of your household during 2009 (include yourself, spouse and dependent children) _____

14. List number of dependent children and ages _____

15. Of the number in question 13, how many will be in college (full or part-time) during 2010-2011? _____

16. **Spouse Information:**
A. Name _____ Age _____ Hometown _____

B. Occupation _____ Employer _____

C. Will spouse attend college in 2010-2011? _____

D. Does spouse have relatives or living experience in rural areas? _____

17. **Applicant and Spouse's Resources during 2009:**

A. Applicant's wages, salaries, tips, etc. (before taxes and deductions) $_____
B. Spouse's wages, salaries, tips, etc. (before taxes and deductions) _____
C. Other taxable income (interest, dividends, etc.) _____
D. Social Security benefits _____
E. Military/Veteran's benefits _____
F. Support from Applicant's parents _____
G. Support from Spouse's parents _____

TOTAL RESOURCES $_____

18. Monthly home mortgage or rental payment: $ _____

19. If you own a home: Year Purchased _____ Purchase Price $ _____

20. **Applicant and Spouse's Assets:**

	Present Value	**Amount of Debt**
A. Cash, savings, checking accounts	$_____	$_____
B. Home (Renters, write "0")	_____	_____
C. Investments (type: _____)	_____	_____
D. Business (type:_____)	_____	_____
E. Farm (type: _____)	_____	_____
TOTAL ASSETS	$_____	$_____

21. Please estimate your 2010 income: Applicant $ _____ Spouse $_____

Will your combined total income differ significantly from the 2009 income reported above?_____
If yes, please explain: _____

22. List all other types of financial aid for which you have applied (***HEAL, Stafford, In-House Medical Loans, NHSC, Military Scholarship, Osteopathic Student Loan, etc***.) _____
_____Are any of these service cancellable? Yes No If so, which?_____

23. Comments or explanations of any special circumstance (give number of question to which you are referring):
_____
_____

THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Applicant's Signature Date

_____ _____
Spouse's Signature Date

Official Notary:
I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____ (applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.
WITNESS my hand and official seal at the City of _____, County of _____ and State of _____, this _____ day of _____, 20___.

_____ My commission expires: _____
Notary Public
Affix Seal

REQUIRED REGISTRATION FOR MILITARY SERVICE

All MALE students born AFTER December 31, 1959 must complete and submit this form with the application for scholarship consideration.

"Article 1 of Chapter 3 of Title 20 of the Official Code of Georgia Annotated, relating to definitions affecting post-secondary education, has been amended by adding at the end of said article a new Code section, to be designated Code Section 20-3-2, to read as follows:

20-3-2. Except as otherwise allowed by law, no person who is required to register for the federal military service draft under 50 U.S.C. Section 453, as amended, shall be eligible to receive any form of state funds under this chapter, including appropriations, grants, bond proceeds, or any other form of funds, unless such person has registered for the draft."

Have you registered for the draft? ____Yes ____No

If so, what is your draft number? _____

The above information is true and correct to the best of my knowledge.

_____ _____

Date Signature

_____

Print your name here

To obtain your draft, call the Selective Service System at **1-847-688-6888** toll free.

You will need your social security number to identify yourself.

To register online, go to **www.sss.gov**

STATE MEDICAL EDUCATION BOARD OF GEORGIA
AUTHORIZATION and RELEASE FORM

FULL LEGAL NAME OF APPLICANT: _____

TO WHOM IT MAY CONCERN:

I, _____, have filed an application with the State Medical Education
Applicant's Full Legal Name
Board of Georgia for a medical scholarship to defray the cost of my tuition and other expenses while attending medical college. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons of high character and recognized ability, who have demonstrated a financial need, are eligible for the award of scholarships. To this end, and for the entire contract period and any subsequent contractual period, I hereby authorize and request any college or school official, institution or organization and any other person or official of any firm, association or corporation, including, but not limited to, those persons whose names I have given as personal references on my scholarship application, to answer any inquires, questions, interrogatories, or furnish any information whatsoever concerning the undersigned on forms or requests which may by submitted to them by the State Medical Education Board or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident in any way to authorized reviews by the State Medical Education Board, or its authorized representative, and fully understand that I shall not be entitled to have disclosed to me the contents of any of the foregoing.

I hereby release and exonerate all such persons authorized by the State Medical Education Board, who shall comply in good faith with this authorization and release from any and all liability of every nature and kind whatsoever growing out of or in any way pertaining to the furnishing of such information or inspection of any document, record and other information or any investigation by said State Medical Education Board.

Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing confidential or privileged communications, as codified in Sections 38-418, 38-419.1 of the Georgia Code Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this _____day of _____, 20___.

_____
Applicant's Full Legal Signature

STATE OF _____ **COUNTY OF** _____

OFFICIAL NOTARY:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____, to me well known to be the person
Applicant's Full Legal Name
described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of _____, County of _____ and State of _____, this _____day of _____, 20___.

_____ My Commission Expires: _____
Legal Signature, Notary Public

(Place Seal Imprint Here)

Rev. 01/10