



HEALTHLEGACYCLEVELAND.ORG

MEDICAL AND DENTAL SCHOOL SCHOLARSHIP APPLICATION ACADEMIC YEAR 2010-2011

PLEASE READ THE FOLLOWING INFORMATION BEFORE PROCEEDING

CONTACT: CYNTHIA CLARK AT 216 621-1933
BY EMAIL TO INFO@HEALTHLEGACYCLEVELAND.ORG

ELIGIBILITY REQUIREMENTS

The Applicant must:

- Be African-American
- Have graduated from a Greater Cleveland area high school
- Show proof of acceptance to a dental or medical school
- Demonstrate a commitment to return to Cleveland to practice medicine or dentistry
- Demonstrate that you require financial assistance to pursue higher education

APPLICATION PROCESS

Your completed application packet must be received by April 2, 2010. Awards will be announced via email no later than May 14, 2010. Recognition at the Health Legacy Board meeting , Thursday, June 10, 2010, Corporate College, 4400 Richmond Rd, Warrensville Hts., Ohio 44128, 6:30 PM. Checks will be mailed directly to the school. U S Mail, Fax or E-mail with PDF Attachments (No Fed Ex to the P O Box) your packet to :

Health Legacy of Cleveland
P. O. Box 201519
Cleveland, Ohio 44120-8108
Fax: 216-621-4174
E-mail: info@healthlegacycleveland.org

Along with the application on the back, a completed package includes:

- Two letters of professional or educational recommendations from individuals other than family members or personal friends
- An official, certified copy of your undergraduate and/or graduate transcripts
- A letter from your financial aid office verifying the amount of financial need
- An essay of 500 words or less explaining what this scholarship would mean to you and why you are committed to the Cleveland area to practice
- The signed Community Service Agreement expressing intent to return to the Greater Cleveland area to practice dentistry or medicine



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MEDICAL AND DENTAL SCHOOL SCHOLARSHIP APPLICATION

ACADEMIC YEAR 2010-2011

Last Name _____ First _____ Middle _____

Email Address: _____

Permanent Address _____ City _____ State _____ Zip _____

Northeast Ohio High School Name _____ Graduation Year _____ Are you a graduate of the Charles R. Drew Saturday Academy? Yes No If yes, what year _____?

Temporary Address _____ City _____ State _____ Zip _____

E-mail Address for notification: _____

Cellular/Personal Phone # _____ Fax: _____

Social Security Number _____ Birth Date ____/____/____ Citizenship: Are you a U.S. Citizen? Yes No If no, what is your alien registration #: A- _____

Name of Undergraduate College or University _____ Major _____

Degree Obtained _____ GPA _____ Graduation Year _____

Name of Medical or Dental School you will attend in academic year 2010-2011: _____

Degree Goal _____ Expected Graduation Date _____

Total family annual income reported on Federal Taxes 2007 \$ _____ 2008 \$ _____ 2009 \$ _____

Total number of family members (include self, siblings, parents, and grandparents if living with you) _____

List dependents, if any, below:

Name _____ Relationship to you _____

Name _____ Relationship to you _____

Name _____ Relationship to you _____

Community Service Agreement

I certify that all statements in this application are true and correct.

I give the college or school I attend permission to provide Health Legacy of Cleveland with information about my financial aid, if necessary.

I give Health Legacy of Cleveland permission to use my name or photograph in publications or on their website should I receive a scholarship award.

I agree to return to the Greater Cleveland community to practice in the fields of medicine or dentistry, if it is within my power to do so.

Signature _____ Date _____

Print Name _____