

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

MEDICAL STUDENT SCHOLARSHIP PROGRAM

WHAT IS THE GOAL OF THE SCHOLARSHIP PROGRAM?

The goal of the Medical Student Scholarship Program is to increase the number of primary care physicians practicing in areas of Illinois that have an insufficient number of physicians in the specialties of family practice, general internal medicine, general pediatrics and obstetrics/gynecology. The program is authorized by the Family Practice Residency Act (110 ILCS 935.1, et seq.).

WHAT METHOD IS USED TO REACH THIS GOAL?

Scholarships for tuition, mandatory fees and living expenses are available to a limited number of eligible medical students. Scholarship recipients repay the awards by completing graduate training in one of the primary care specialties and by practicing in areas of Illinois determined by the Illinois Department of Public Health to be physician shortage areas.

WHO IS ELIGIBLE FOR A SCHOLARSHIP?

To be eligible to receive a scholarship, a student must be an Illinois resident accepted for or enrolled in an allopathic or osteopathic medical school located in Illinois. Students waiting for confirmation of acceptance to medical school may apply. An applicant must demonstrate financial need. The medical school will be asked to attest to the applicant's good academic standing and financial need. Only students who will pursue one, or a combination, of the primary care specialties of family practice, general internal medicine, general pediatrics or obstetrics/gynecology will be eligible for scholarship funds.

Selection preference will be given to applicants who meet the above criteria and who demonstrate 1) a commitment to primary health care; 2) greatest financial need; and 3) prior experience with populations whose health care needs are underserved. When all factors are equal, preference is given to applicants who have resided in Illinois for the longer period of time.

HOW DOES THE SCHOLARSHIP PROGRAM WORK?

Scholarship applications will be available at the financial aid offices of Illinois' allopathic and osteopathic medical schools. **Completed applications must be postmarked no later than May 15, 2005.** The Department may interview applicants as part of the selection process. Announcement of the students selected for awards is scheduled for September. The scholarship awards will pay tuition, fees (matriculation fees and mandatory insurance) and living expenses of \$950 a month for 12 months per year. Scholarship awards are sent to the medical schools for disbursement.

WHAT ARE THE DETAILS CONCERNING SCHOLARSHIP REPAYMENT?

Before receiving a scholarship, each applicant will enter into a binding contract with the state of Illinois to meet conditions of the scholarship. Failure to meet the terms of the contract will require the recipient to reimburse the state three times the total amount of the scholarship over the same period of time financial assistance was provided.

Within 30 days after completing residency training, the scholarship recipient begins to repay the award by establishing an office-based practice in an area in Illinois designated by the Department as having a shortage of primary care physicians. Fellowships in a primary care field, generally one year in length after residency, are allowable when approved by the Department. Time spent in residency or fellowship does not repay any part of the service obligation. The recipient must practice on a full-time basis, one year for each year scholarship funds were received. The physicians are considered to be in private practice and are not employees of the Department. Private practice may be as an individual or in a group. Physicians working in hospital settings must work full-time in ambulatory patient care through an outpatient clinic. Both salaried and fee-for-service practice arrangements are acceptable.

For evaluation and approval of practice locations, a scholarship recipient must contact the Department prior to entering into a formal agreement with an individual or facility. Practice locations will be approved up to 18 months prior to initiating the service repayment.

Scholarship recipients will not be placed in default of the contract for lack of designated shortage areas. As the physician population increases in Illinois, the designation criteria will be updated to ensure a sufficient number of areas from which to choose a practice location. The Department will not assign scholarship recipients to selected areas.

WHAT ARE THE DETAILS CONCERNING A PRACTICE SITE LOCATION?

If an applicant desires to practice in a particular city or county, serious consideration should be given to the importance of this preference before applying for this scholarship. Applicants will need to be flexible as physician shortage areas in the state change. A current list of physician shortage areas is available from the Department.

Selecting a suitable practice location to fulfill an obligation is the responsibility of the scholarship recipient. Department staff will provide current lists of shortage areas to the recipient. Included on the list will be the names of local health professionals or other individuals who may be able to answer questions regarding specific areas. The Department will consider new geographic locations for designation as physician shortage areas. The proposed locations may be submitted by scholarship recipients, medical schools, community hospitals, local physicians or community organizations. In all instances, practice must begin within 30 days of licensure or the recipient's departure from a residency program.

Illinois Department of Public Health

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Application for Funding
July 1, 2005 – June 30, 2006

Applications for scholarship assistance for the
2005-2006 academic year must be
postmarked no later than May 15, 2005.

Applicant's Name _____
(Last) (First) (M.I.)

Home Phone (____) _____ Date of Birth _____

Cell Phone (____) _____

Applicant's Mailing Address

(Street Address)

(City) (State) (ZIP Code)

Applicant's E-mail Address _____

Parents' Names _____
(Last Name) (Father's Name) (Mother's Name)

Parents' Mailing Address _____
(Street Address)

(City) (State) (ZIP Code)

Parents' Home Phone (____) _____

Have you applied for the Medical Student Scholarship before? Yes _____ No _____

If yes, in which year(s) did you apply? _____

Are you a U.S. citizen? Yes _____ No _____

If you are NOT a U.S. citizen, please complete the following:

How long have you been in the U.S.? _____

Does your family live in the U.S.? _____

Do you plan to become a citizen? Yes _____ No _____
If yes, when? _____

Are you currently enrolled in an Illinois medical school? Yes _____ No _____

If yes, which school? _____
Campus Location? _____

If no, have you been accepted to an Illinois medical school?

Yes _____ No _____

If yes, please list schools and campus location:

What year in medical school will you be completing in 2005-2006?

First Year _____ Second Year _____

Third Year _____ Fourth Year _____

Have you repeated any year(s) of medical school? Yes _____ No _____

If yes, which year(s) and for what reason: _____

Are you on academic probation? Yes _____ No _____

Have you taken national boards?

Not yet _____

Part I: Passed _____ Failed _____

Part II: Passed _____ Failed _____

Number of times failed _____ Awaiting Results _____

When do you anticipate graduating from medical school? _____
(Month) (Year)

Do you have any commitments that would affect your ability to practice in Illinois following residency training? Yes _____ No _____

If yes, explain: _____

If you are married, does your spouse have any commitments that would affect your ability to practice in Illinois following residency training? Yes _____ No _____

If yes, explain: _____

How many years have you lived in Illinois? _____

If married, how many years has your spouse lived in Illinois? _____

In what other states have you lived and for how long? (List most recent first.)

(State) (Date) (State) (Date) (State) (Date)

In what city and state did you graduate from high school?

(City) (State)

In what state did you (will you) receive your undergraduate degree? _____

Will you pay in-state tuition at your medical school? Yes _____ No _____

Indicate first and second medical specialty preference:

Family Practice _____ General Internal Medicine _____

Obstetrics/Gynecology _____ General Pediatrics _____

Pediatrics/Internal Medicine _____ Undecided _____

Do you have a preference for practice location?

Rural underserved area _____ Either _____

Urban underserved area _____ Undecided _____

Community population preference

< 10,000 _____ 10,000 - 50,000 _____ > 50,000 _____

SOCIAL SECURITY NOTICE

The Illinois Department of Public Health requests your Social Security number. You are not required to disclose your Social Security number at this time, and no rights, benefits or privileges will be denied if you choose not to disclose your number. Be advised, however, your Social Security number will be required at a later date if you are selected to receive scholarship funds through the Medical Student Scholarship Program. If you agree to disclose your Social Security number, it will be used for collecting financial aid information from your school.

If you disclose your Social Security number, please sign this section.

Social Security Number ____ - ____ - ____

Signature _____

Date _____

CERTIFICATION

I certify that I am not presently in default on payments for any previously received state or federal loan funds. I also hereby certify the information submitted in this application is a true record.

Signature _____

Date _____

APPLICANT'S AUTOBIOGRAPHICAL PROFILE

In narrative format, please provide the information requested below. Address each item individually and limit your responses to **one typed page per question**. Additional pages will not be considered.

1. Describe any experience you have had with medically underserved populations. Include experiences you initiated, as well as experiences requested by your school.
2. Describe any experience that significantly influences your choice of medical specialty.
3. Describe your career goals, including the type of practice you want.
4. Describe any special circumstances affecting your financial status.

To be considered complete, applications **must include the following:**

1. This application form, pages three - seven.
2. The student autobiographical profile (see page six of application).
3. One of the following:
 - a. For students entering first year - a copy of your AMCAS Application or a copy of the AACOMAS Applicant Profile for osteopathic students
 - b. For all other medical students - transcript or verification from the college of student's grade point average

OPTIONAL INFORMATION

Ethnic Origin:

American Indian	_____	Hispanic	_____
Asian or Pacific Islander	_____	White, Not Hispanic	_____
Black, Not Hispanic	_____	Other	_____

Applicants will be considered for funding from July 1, 2005, to June 30, 2006, and will be notified when the completed application is received. If the application is incomplete, you will receive ONE request to send the missing information.

If you have any questions, please contact your financial aid officer first. Further questions may be directed to the Medical Student Scholarship Program at 217-782-1624 or TTY (hearing impaired use only) 800-547-0466.

Return completed application to: Medical Student Scholarship Program
Illinois Department of Public Health
Center for Rural Health
535 W. Jefferson St.
Springfield, IL 62761

