Leadership Scholarship Application

Please complete this application and return to wim.doctors@gmail.com along with your CV. One letter of recommendation is required, but we will accept two. A letter of good standing from your school is also required. All letters must be emailed directly by the authors to wim.doctors@gmail.com with your name as the subject line.
All applications and letters must be received by April 1, 2018.

I give permission to officials of my institution to release information regarding my academic record and other information requested for consideration in the Women In Medicine Leadership Scholarship. I waive the right to access letters of recommendation written on my behalf.

- ☐ Yes
- ☐ No

I understand that this application will be available only to qualified people who need to see it in the course of their duties. I affirm the information contained herein is true and accurate to the best of my knowledge and belief.

- ☐ Yes
- ☐ No

If selected as a Women In Medicine Scholar, I understand I am required to attend the full conference and it's sessions that will be held in Napa, CA on August 5 to August 9, 2018.

- ☐ Yes
- ☐ No

PERSONAL INFORMATION

LAST NAME: _____

FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH (dd/mm/yyyy):

PHONE NUMBER:

LAST NAME:

How do you identify (select all that apply)

- [ ] Lesbian
- [ ] Bisexual
- [ ] Transgender Female
- [ ] Queer/Gender-Queer
- [ ] Transgender Male
- [ ] Other

How do you identify (select all that apply)

- [ ] American Indian or Alaskan Native
- [ ] Asian
- [ ] Black
- [ ] Native Hawaiian or Pacific Islander
- [ ] White
- [ ] Hispanic or Latino
- [ ] Non-Hispanic or Latino
- [ ] I'd rather not answer
- [ ] Other

EDUCATION

List your previous schools, beginning with the most recent Medical School followed by undergraduate/post-graduate institution(s).

MEDICAL SCHOOL

CITY:

STATE:

DATE OF ENTRY

EXPECTED DATE OF MATRICULATION:

G.P.A.:

LAST NAME:

NAME OF SCHOOL:

CITY:

STATE:

START DATE: END DATE:

G.P.A.:

DEGREE OBTAINED:

NAME OF SCHOOL:

CITY:

STATE:

START DATE: END DATE:

G.P.A.:

DEGREE OBTAINED:

LAST NAME:

List all LGBT-related organizations (both in the community and your institution) and activities you have been involved with, and designate any leadership roles and/or recognitions where applicable (you can explain further in #10, if you desire):

List all other college, post-grad and medical school activities and organizations you have actively been involved with, including any leadership roles and/or recognitions you have received as a result of your involvement:

List any research experience, including dates and publications:

LAST NAME:

List any part-time or full-time employment experience, including dates and a brief description of duties:

List any additional awards, scholarships or special recognitions you have received (do not duplicate those listed above):

Describe one or two specific examples of your leadership within the LGBT communities (if applicable):

LAST NAME:

Describe your future goals in medicine:

Describe how you would like to use your role as an LGBT medical student/physician to better the LGBT communities:

If selected as a Women In Medicine Scholarship recipient, how would you contribute to the organization to further its mission?

LAST NAME:

What additional information would you like to share with Women In Medicine?