

**UNIVERSITY OF SOUTH FLORIDA  
COLLEGE OF MEDICINE  
2011 - 2012  
FINANCIAL AID APPLICATION  
for M.D. Students**

NAME \_\_\_\_\_  
Last First Middle Preferred Name USF ID

2011/12 Grade Level (Please check one): MD1 \_\_\_\_\_ MD2 \_\_\_\_\_ MD3 \_\_\_\_\_ MD4 \_\_\_\_\_

*The Free Application for Federal Student Aid (FAFSA), with both parents information provided, must be completed to determine eligibility for the College of Medicine Need Based Loans and Scholarships. For merit based awards parental information is not needed.*

Will you be providing your parents' financial information? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how will you provide your parents information? Please select one.

\_\_\_\_\_ Both parents' information will be provided with my online FAFSA.

\_\_\_\_\_ ♦ Mother's information will only be provided with my online FAFSA and Father's information via a paper FAFSA.

\_\_\_\_\_ ♦ Father's information will only be provided with my online FAFSA and Mother's information via a paper FAFSA.

\_\_\_\_\_ Other, please explain: \_\_\_\_\_

♦ If you provide only one of your parent's information online, it will be necessary for the second parent to complete a paper FAFSA directly to the USF College of Medicine Financial Aid Office.

Place of Birth: \_\_\_\_\_  
City State County

High School: \_\_\_\_\_  
Name of High School City State County

Permanent Address: \_\_\_\_\_  
City State County

Do you consider yourself a disadvantaged student? (i.e. first generation in college, racial or ethnic group that is underrepresented in medicine, economically disadvantaged, etc.) \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide a written statement with this application outlining your disadvantaged background.

As an undergraduate did you participate in intercollegiate athletics? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide a written statement with this application outlining your intercollegiate athletics achievements.

Have you decided what area of medicine you plan to practice? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please indicate which area (i.e. Family Medicine, Internal Medicine, Surgery, etc.). \_\_\_\_\_

Are you interested in the Primary Care Loan Program (PCL)? Yes \_\_\_\_\_ No \_\_\_\_\_

The PCL program requires a commitment to train and practice in Primary Care (family medicine, general internal medicine, general pediatrics or preventive medicine). *If you wish to be considered, a written statement must be provided with this application which explains your commitment and willingness to complete the program requirements.*

**CERTIFICATIONS:**

Your signature certifies that you understand that:

- If you purposely give false information (written or verbal) it will be considered a violation of the "University of South Florida College of Medicine Honor Code."
- The selection committee may review your academic records, financial information, and other records as needed to make award decisions.
- If you receive an award your name may be shared with the donor(s) or their designee.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date