| AFLESR HEalth sciences scholarship application for Residents seeking Research Funds |
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| Applicant Information |
| Name: |
| Date of birth: | Phone: | Email:  |
| Current address: |
| City: | State: | ZIP Code: |
| SChool information |
| Undergraduate University: |
| Undergraduate Major and Minor: |
| Undergraduate GPA: |
| Medical School: |
| Medical School GPA and Rank: |
| Current Residency  |
| Years in Residency: |
| Current Residency Location: |
| Residency Research Project: |
| Letter of recommendation |
| Please provide one letter of recommendation with your application of a distinguished professor or mentor concerning your character, work ethic, and promise in the field. |
| Signature |
| I authorize the verification of the information provided on this form and approve my application to the AFLESR Health Sciences Scholarship.  |
| Signature of applicant: | Date: |

Please send application, with letter of recommendation and a cover letter to:

Dr. John Joseph Anderson, DPM

jsdsbanderson@aol.com