| AFLESR HEalth sciences scholarship application for Residents seeking Research Funds | | | | |
| --- | --- | --- | --- | --- |
| 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