SCHOLARSHIP APPLICATION

PROGRAM OBJECTIVES for Scholarships

AMDPA has two scholarship programs (The AMDPA General Scholarship and the Joe Hargrove Scholarship) for disadvantaged students pursuing careers primarily in medicine, dentistry and pharmacy at accredited institutions.

The AMDPA General Scholarship Program annually awards up to three (3) scholarships annually to medical, dental and pharmacy students. The Joe Hargrove Scholarship Program will award one (1) scholarship to either a medical, dental or pharmacy student.

Applications are generally available August/October of each year. The deadline for submission in is **December 30th.**

The AMDPA Scholarship Program supports the mission of the Arkansas Medical, Dental and Pharmaceutical Association by:

- Increasing awareness of and respect for cultural differences in the African American community as it relates to healthcare.
- Instilling in scholars the medical ideal of "Service Above Self" through the active participation in medical service projects.
- Encouraging scholars to dedicate their personal and professional lives to improving the quality of life for the people of their home communities.
- Developing healthcare professionals who can address the medical needs of the African American community.
- Fostering a lifelong association between AMDPA and its scholarship recipients.

Candidates should consider these objectives carefully before applying and be prepared to explain in their essays how their study plans will support the program objectives. Scholars are encouraged to request to practice in Arkansas. Other ways of demonstrating support of the objectives include a commitment to community service or humanitarian service and a commitment to long-term involvement with AMDPA.

Scholarship recipients are encouraged to support program objectives by choosing a specialty, which will help address the needs of healthcare in the community.

AMDPA seeks out students who are prepared for the challenge of serving as outstanding healthcare professionals. If you receive a scholarship, you will be expected to participate in the AMDPA activities as part of your mission as an AMDPA scholarship recipient

All applicants must complete the application in full and postmarked by December 30th in order to be eligible for the AMDPA Scholar-ship.

APPLICATION INSTRUCTIONS

Application forms and required documents must be post-marked on or before December 30th.

General Scholarship Application Instructions

This page is not a part of the application and need not be submitted.

1. Scholarship applications should be typewritten. If you cannot type, complete the form in black ink so that it photocopies easily. Do not alter the application.

2. **Request an unofficial grade transcript from the Admission/Records office.**
   Provide transcript(s) from all professional schools you are actively attending. Copies are acceptable.

3. Be sure to meet the scholarship application deadlines

4. All scholarships require at least two letters of recommendation.

5. RECOMMENDATION FORMS
   Applicants should complete Section I and should have academic instructors or appropriate employers/supervisors complete Section II of the Recommendation Forms of this application. Educators or employers/supervisors completing these recommendations for you should be informed of the purpose of an AMDPA scholarship.

ANNOUNCEMENT OF AWARDS

The Scholarship Committee will review the applications. Recipients of the scholarship awards will be notified by on or before December 30th.

Forward the complete application to:

AMDPA
Scholarship Committee
P. O. Box 55104
Little Rock, AR 72215

SCHOLARSHIP APPLICATION

Please check the scholarship type for which you are applying.

❒ Medical Student ❒ Pharmacy Student ❒ Dental Student ❒ PA Program Student

Personal Information (Please type or print):

Last Name: _____ First Name: _____ MI _____

Address: _____

City: _____ State: _____ Zip: _____Country if outside USA: _____

Hometown: _____State of Residence: _____

Telephone Number: (_____) _____ Mobile Number: (_____) _____

Email Address: _____

Are you: ❒ U.S.Citizen ❒ U.S. National ❒ U.S. Permanent Resident

EDUCATIONAL BACKGROUND/HISTORY:

Undergraduate College:

Name of College: _____ City: _____ State: _____

Attended from: _____ to: _____ Graduation Date: _____ Degree: _____

Major: _____ Minor: _____ G.P.A.: _____

Awards and Scholastic Honors Received: _____

_____

_____

Activity in College, professional school and Community Organizations: _____

_____

_____

Graduate Level Work/Professional School: (other than Medical School)

Name of College: _____ City: _____ State: _____

Attended from: _____ to: _____ Graduation Date: _____ Degree: _____

Major: _____ Minor: _____ G.P.A.: _____

Awards and Scholastic Honors Received: _____

_____

Professional School:

If you have not started Medical, Dental or Pharmacy School this year please list the School(s) to which you have been accepted.

School **City** **State**

_____

_____

_____

If you are already in Medical, Dental or Pharmacy School, please complete the following:

School: _____ City: _____ State: _____

Major Field of Interest:

_____

_____

_____

School attending at time of application: _____

Expected Graduation Date: _____

Academic Status: ❒ Freshmen ❒ Sophomore ❒ Junior ❒ Senior

❒ Honors ❒ High Pass ❒ Pass ❒ Low Pass ❒ Failing

Are you a member of SNPhA, SNDA or SNMA? ❒ Yes ❒ No Are you a member of AMDPA? ❒ Yes ❒ No

Do you plan to practice in Arkansas? □ Yes □ No. If no, where do you plan to practice? _____.

What percentage of your educational expenses is to be paid by?

Family _____ % Yourself _____ % Scholarship or grant _____ % Loan_____ %

Are you a first-generation medical, dental or pharmacy student? ❒ Yes ❒ No

Community Service Activities: _____

_____

_____

_____

_____

_____

PERSONAL STATEMENT

Please write one to three pages, which describe your educational plan. This will include short and long-range goals (personal and professional), including the reasons for your choice. Please include a personal statement that describes your uniqueness and any other information about yourself, which you feel might be helpful in determining your eligibility for a scholarship, including how this scholarship will assist you.

I certify that this application and all attachments are complete and true. I hereby authorize AMDPA to furnish copies of my academic record, this application, and letters of recommendation to the Scholarship Selection Committee for review. If selected, I further authorize release of information for publicity purposes.

I understand that it is my responsibility to report any scholarship(s) that exceed medical, dental or pharmacy school costs, as earned income on my Federal Income Tax Return.

APPLICANT'S SIGNATURE _____ DATE _____

Are you currently an active member of AMDPA: ❒ **Yes** ❒ **No**

RECOMMENDATION FORM

Scholarship Year 2025

(**NOTE**: Two (2) Letters of Recommendation are required)

(Two people, one of whom is a faculty member, who are personally acquainted with your performance, capabilities, and potential.)

Section I - To be completed by applicant.

APPLICANT'S NAME (PLEASE TYPE OR PRINT)

SIGNATUJRE

Section II – To be completed by instructor or advisor.

1. In what capacity and how long have you known the applicant?

2. How firm the applicant's commitment to his/her is proposed field of study?

3. How would you rate the application the following area? (If you are unable to evaluate an area, please leave blank.)

	Excellent	Very Good	Average	Below Average
Leadership	○	○	○	○
Initiative	○	○	○	○
Purpose Driven	○	○	○	○
Enthusiasm	○	○	○	○
Maturity	○	○	○	○
Community Service	○	○	○	○

4. Please cite specific examples of how the applicant has demonstrated the qualities listed in Question 3.

5. Additional Comments

Name: _____ Title/Occupation: _____

Institution: _____

Telephone: _____Fax: _____ Email: _____

Signature: _____ Date: _____

Please return completed evaluation to:

AMDPA Scholarship Committee
P. O. Box 55104
Little Rock, AR 72215-5104.