HOSPITAL FOUNDATION OF DECATUR COUNTY, INC.
MEDICAL STUDENT TUITION ASSISTANCE PROGRAM

Each academic year in the Fall semester, the Hospital Foundation of Decatur County, Inc. (the *Foundation*) Medical Student Tuition Assistance Program will award up to Twenty Thousand Dollars ($20,000.00) per semester (*Tuition Assistance*) to up to two individuals who graduated from a high school in Decatur County or a surrounding county and agrees to return and practice medicine in Decatur County (the *Recipient(s)*).

Eligibility and Terms

(1) Eligible applicants must:

a) be a graduate of a high school located in Decatur County, Indiana or a surrounding county;

b) be actively enrolled on a full-time basis in a medical school approved by the Indiana Medical Licensing Board pursuing a degree of Doctor of Medicine or Doctor of Osteopathic Medicine;

c) agree to practice medicine in Decatur County, Indiana upon completion of medical school and residency; and

d) authorize the applicant's medical school to release transcripts to the Foundation to verify compliance with eligibility requirements.

(2) The Foundation will provide Tuition Assistance directly to the Recipient's medical school to be documented as a loan from the Foundation to the Recipient (the *Loan*).

a) The Loan balance is due in full *plus* accumulated interest of 1.5% per annum within twelve (12) months following the Recipient's last semester of enrollment in medical school.

b) However, the Foundation agrees to forgive the Loan in full if the Recipient:

(i) attains an unlimited license to practice medicine in Indiana, and

(ii) either:

(A) practices medicine as an employee of Decatur County Memorial Hospital or its affiliates for at least forty-eight (48) months; or

(B) if the Recipient is not offered employment with Decatur County Memorial Hospital or any of its affiliates, practices medicine in independent practice in Decatur County, Indiana for at least forty-eight (48) months, while also maintaining admitting privileges as an active member of the Decatur County Memorial Hospital medical staff.

(3) Recipients that successfully complete the Fall semester will automatically receive Tuition Assistance for the following Spring semester. The Recipient must submit a copy of the Recipient's transcript to the Foundation upon the conclusion of each semester to demonstrate continued enrollment.

(4) The Tuition Assistance is renewable annually so long as the Recipient remains enrolled in an eligible medical school. Tuition Assistance awarded for any one school year is not a guarantee of future tuition assistance funds.

Application

Submit each of the following:

(1) A completed application.

(2) An essay describing the reason(s) you are pursuing a career in medicine and the specialty(ies) in which you intend to practice. Essays may not exceed 5,300 characters (including spaces).

(3) High school transcript or diploma.

(4) Undergraduate transcript.

(5) An applicant already enrolled in medical school for at least one semester must also submit a copy of their most recent medical school transcript.

(6) A letter of acceptance from a medical school approved by the Indiana Medical Licensing Board.

(7) Three (3) letters of reference from individuals that know you well and can speak to your performance as a student or your work experience. The letters of reference may not come from immediate or extended family members.

(8) Pages 1 and 2 of your Student Aid Report (*SAR*). (The SAR is a part of your FAFSA Application).

Procedure

(1) Submit completed applications and all supporting documents either in hard copy or electronically:

via U.S. Mail to: Hospital Foundation of Decatur County
720 N Lincoln St.
Greensburg, IN 47240
Attn: Mandy Lohrum, Director

- or -

via E-Mail to: Foundation@dcmh.net
Subject: HFDC Medical Student Tuition Assistance Program

(2) Completed applications and supporting documents must be submitted to the Foundation **no later than May 15th** for the Fall semester. Late or incomplete applications will not be considered.

HOSPITAL FOUNDATION OF DECATUR COUNTY MEDICAL SCHOLARSHIP APPLICATION

(Information submitted may be shared with DECATUR COUNTY MEMORIAL HOSPITAL Human Resources.)

PERSONAL INFORMATION:

NAME: _____
(First) (Middle Initial) (Last)

HOME ADDRESS: _____
(Street)

_____ Phone: (____) _____ - _____
(City) (State) (Zip)

E-mail: _____

Age: ____ Sex: ____ SSN: _____ - ____ - _____ County of Residence: _____
Father's Name: _____ Occupation: _____
Father's Address: _____
Mother's Name: _____ Occupation:_____
Mother's Address: _____
Number and ages of siblings (indicate if in college): _____
_____
Marital Status: _____ if married, spouse's name: _____
Occupation of Spouse: _____ No. Children: _____ Ages: _____

EDUCATIONAL BACKGROUND

List of School(s) Attended	Location	Years	Major/Course of Study
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical school where you have been accepted: _____
Anticipated degree: _____
Anticipated date of graduation: _____

Career objectives: _____
_____
_____
_____

EXTRACURRICULAR ACTIVITIES

Please list organizations, clubs, and athletics you have been involved with, including years of involvement and leadership positions held:

_____
_____
_____

Honors and awards you have received:

_____
_____
_____

Community Activities:

_____
_____
_____

EMPLOYMENT HISTORY (PAST AND PRESENT)

Job Title/Description	Hours Worked/Wk	Period of Employment
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

☐ I am a current DCMH employee. If yes, Department: _____
☐ I am a current DCMH employee tuition assistance participant.
☐ I have previously worked at DCMH. If yes, please give specifics:

_____

FINANCIAL RESOURCES

Estimated annual cost of attending school: $ _____
Estimated parent contribution: $ _____
Estimated student contribution: $ _____
List of current scholarships, grants, and funds:

_____ $ _____
_____ $ _____
_____ $ _____

Existing educational loan balances:

_____ $ _____

Other financial considerations: _____

_____

I certify that the information on this application is true and accurate to the best of my knowledge. I understand that information contained in this application and its supporting documents becomes property of Decatur County Memorial Hospital and the Hospital Foundation of Decatur County.

_____ _____
(Applicant's Signature) (Date)