



350 ST. ANDREWS ROAD ■ SUITE 242 ■ SAGINAW, MI 48638-5988 ■ (989) 790-3590 ■ FAX (989) 790-3640
EMAIL: JMCRAMER@SBCGLOBAL.NET ■ WWW.SAGINAWCOUNTYMS.COM

MEDICAL STUDENT LOAN APPLICATION

The Saginaw County Medical Society (SCMS) Foundation was established in 1968 and is funded through physician donation of earnings from educational and charity work. The SCMS Foundation makes low interest loans to medical students with ties to the Saginaw area. In the past, the amount of each loan has ranged anywhere from \$1,000 to \$10,000 with some students receiving loans several years in a row. Maximum loans awarded during medical school is \$20,000 per student.

The terms of these loans are generous. No interest is charged while the student is in medical school, simple interest is charged at a rate of four percent per annum during a residency program, and interest is charged at a rate of eight percent per annum upon completion of a residency program.

As of 2012, the Foundation Board voted to forgive all interest if the student returns to Saginaw upon completion of their residency to practice. Additionally, the Board voted in May 2016 to start a loan forgiveness program. If the loan recipient returns to Saginaw to practice upon completion of their residency and they are a dues paying member of the SCMS/MSMS, 25 percent of the principal balance will be forgiven at the end of each year they are practicing in Saginaw County, with a maximum of \$5,000 per year forgiven.

The Foundation Board generally considers students who are past their first year of medical school, and among other things, according to:

- ***Strength of connection to Saginaw***
- ***Financial need***
- ***Scholastic performance***
- ***Community service/extracurricular activities***

The intent of the Foundation loans are to assist and encourage students to return to Saginaw to practice medicine.

Only applicants enrolled in a United States medical school will be considered.

If you would like to be considered for a loan, please complete the attached application and return with required documentation and signature, per the application, to the SCMS Foundation by March 31, 2018. The Foundation Board will review your application and will notify you as soon as they have made a decision (generally by the second week in May).



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DUE DATE: MARCH 31, 2018

Only applicants enrolled in a United States medical school will be considered.

APPLICATION FOR FINANCIAL ASSISTANCE FOR EDUCATIONAL PURPOSES

The completed application with all information, signatures, notary and medical school verification should be emailed to jmcramer@sbcglobal.net. *In addition to submitting by email, the original signed and notarized application and documentation must be mailed to the address above. Incomplete applications will NOT be considered.*

I. PERSONAL

DATE _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth ____/____/____ Place of Birth _____ Sex ☐ Male ☐ Female

Social Security Number ____-____-____ Email _____

Driver's License Number ____-____-____-____-____ License State _____

Current Address _____

Telephone (____) _____

Permanent Address _____

Telephone (____) _____

Marital Status ☐ Single ☐ Married Spouse's Name _____

Spouse's Occupation _____

Spouse's Cell Number (____) _____ Spouse's Email _____

Undergraduate College/University _____

Year Graduated _____ Degree _____

Medical School _____

Year of Study ☐ M1 ☐ M2 ☐ M3 ☐ M4 Student ID#: _____

****Applicant MUST submit an official letter from their Medical School with complete contact information (name, position, address, phone, fax and email) verifying enrollment and year of study as of the date of this application.****

Father's Name _____ Occupation _____

Current Address _____

Telephone (_____) _____ Email _____

Mother's Maiden Name _____ Occupation _____

Current Address _____

Telephone (_____) _____ Email _____

II. INTERVIEW

A. In what ways, if any, have you contributed toward your own support or your own savings?

B. Do you intend to work while continuing your education?

C. Amount saved toward school expenses:

D. Have you applied, or do you intend to apply for, other scholarships or loans?

E. List scholarships or grants already received:

F. In what way do you think you will benefit by continuing your education?

G. How might your education benefit Saginaw County?

H. Of all the things you have accomplished in or out of school, which have given you the greatest personal satisfaction?

III. On a separate sheet, please provide a brief story of your life. (Please include what person or event most influenced your plans for the future; which studies you liked best (and least); your ambitions, interests, aims, ideals, philosophy of life, hobbies, etc.).

Please include a current CV.

PLEASE CONTINUE TO PAGE 5

IV. PLEASE COMPLETE THE FOLLOWING BUDGET (in approximate figures)

INCOME	LAST YEAR ATTENDED	YEAR FOR WHICH ASSISTANCE IS REQUESTED
Cash on hand at beginning of school year	\$	\$
Income from parents		
Income from spouse		
Earnings expected		
Income from other sources (explain)		
Loans (received or pending)		
Gifts or scholarships		
TOTAL INCOME	\$	\$
EXPENSES		
Tuition and fees	\$	\$
Room and board		
Books and instruments		
Clothing		
Laundry, recreation, misc.		
Transportation		
TOTAL EXPENSES	\$	\$
AMOUNT OF LOAN REQUESTED		\$

I fully understand that any significant misstatements in, or omissions from this application, constitute cause for denial of a loan and/or for any loans previously granted to me to be immediately due and payable in full with interest. All information submitted by me in this application is true to my best knowledge and belief. **A collection agency will be used immediately if there is a default on the loan, or lack of communication indicates potential default.**

I further agree to contact the SCMS Foundation on or before March 31 of each year by email or postal mail with my updated contact and medical school/residency information. Current contact information can be found at www.SaginawCountyMS.com.

Signature (e-signature not valid) _____ Date: _____

PLEASE CONTINUE TO PAGE 6

AUTHORIZATION TO RELEASE PRIVILEGED INFORMATION

I hereby authorize _____
Insert name of medical school above

to verify my education and release any other requested information related to my enrollment, including but not limited to participation, programs, contact information, and status to the **Saginaw County Medical Society Foundation, 350 St. Andrews Road, Suite 242, Saginaw, Michigan 48638-5988, phone 989-790-3590, fax 989-790-3640** for ten (10) years from the date of this Authorization.

Date: _____, 20____ Student ID#: _____ Date of Birth: ____/____/____

Name: _____
Last Name First Name Middle Initial

Address: _____

Telephone: (____) _____ Email: _____

Year of Study as of the Date of this Authorization: ☐ M1 ☐ M2 ☐ M3 ☐ M4

Signature: _____
(e-signature not valid)