

**PHYSICIAN MANPOWER TRAINING COMMISSION  
Physician Assistant Scholarship Program**

**APPLICATION**

**PLEASE PROVIDE A HEAD AND SHOULDERS PHOTO WITH THIS APPLICATION**

**APPLICANT**

Name \_\_\_\_\_ SS# \_\_\_\_\_  
(First, Middle, Last)

Address \_\_\_\_\_  
(Street/P.O. Box, City, State and Zip)

E-Mail Address \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Cell Number ( ) \_\_\_\_\_

Birth Date \_\_\_\_\_ Hometown \_\_\_\_\_

Parents Name, Address and Phone Number \_\_\_\_\_

**SPOUSE** Marital Status \_\_\_\_\_

Spouse Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ SS# \_\_\_\_\_

Spouse Occupation \_\_\_\_\_ Spouse Hometown \_\_\_\_\_

Number of Children \_\_\_\_\_ Ages \_\_\_\_\_

Parents Name or Nearest Relative \_\_\_\_\_

Address and Phone No. \_\_\_\_\_

<b>College(s)</b>	<b>Dates Attended</b>	<b>Degree</b>
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\_\_\_\_\_  
\_\_\_\_\_

Physician Assistant Training Level \_\_\_\_\_ PA applicant \_\_\_\_\_ 1st year \_\_\_\_\_ 2nd year \_\_\_\_\_ 3rd year

Location of PA Training and Anticipated Date of Completion (Mo/Yr) \_\_\_\_\_

Do you presently have any scholarships or loans that have a practice obligation? \_\_\_ Yes \_\_\_ No

If yes, please explain \_\_\_\_\_

**Physician Assistant Scholarship Program Application Continued**

**SELECTION CRITERIA**

If the number of applicants exceed the availability of funds the following items will be used as selection criteria; (PLEASE ENCLOSE THE FOLLOWING WITH COMPLETED APPLICATION)

- 1) Latest Federal Income Tax form 1040, 1040A or 1040EZ. Dependent students must send parent's income tax form in addition to their own.
- 2) Transcript of all college work.
- 3) Medically related job experience. Please list location and dates of employment.
- 4) Acceptance Letter from PA School. (Preference given to those attending Oklahoma Programs)

In what extra-curricular activities (community, hobbies, vocational) have you participated while in college and/or postgraduate training? \_\_\_\_\_




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List, in order of preference, the rural communities or areas in which you prefer to practice:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_


Please read and initial each statement below:

I understand that participation in the PMTC Physician Assistant Scholarship Program requires me to:

- Be a resident of the State of Oklahoma \_\_\_\_\_ 
- Practice in a community of 20,000 or less population upon completion of training \_\_\_\_\_ 
- Serve one month for each month the scholarship was received in a PMTC approved community \_\_\_\_\_ 

I hereby declare that the information contained in this application is true and correct.  
I hereby authorize the Physician Manpower Training Commission to request and receive any and all information related to the administration and enforcement of the applicable repayment agreement and promissory note.

The Physician Manpower Training Commission, in compliance with Title VI of the Civil Rights Act of 1974 and Title IX of the Education Amendments of 1972 (Higher Education Act), does not discriminate on the basis of race, color, national origin or sex in any of its policies, practices, or procedures. This provision includes, but is not limited to, employment and financial services.

Signature of Applicant \_\_\_\_\_ 

Date of Application \_\_\_\_\_

Please return to:

Physician Manpower Training Commission  
5500 North Western Avenue, Suite 201  
Oklahoma City, Oklahoma 73118  
(405) 843-5667 FAX (405) 843-5792