

**APPLICATION FOR PARTICIPATION
IN THE KANSAS MEDICAL STUDENT
LOAN PROGRAM
SCHOOL YEAR 2007-2008**

Return this form to:
The University of Kansas Medical Center
Department of Student Financial Aid
3901 Rainbow Blvd.
4003 Student Center
Mail Stop 4005
Kansas City, Kansas 66160-7192

Office Use Only:

P _____ Group _____

B _____

H _____

(913) 588-5170 Phone (913) 588-8841 Fax
E-mail: financialaid@kumc.edu

Deadline: February 14th, 2007

Note: All first time applicants must file the Free Application for Federal Student Aid in order to be considered for this assistance. This is an application to participate, and should not be construed as a guarantee of support from this program.

Name of Applicant _____
Last First Middle Initial

Social Security Number _____ KUMC Student ID _____ Date of Birth _____

Present Mailing Address _____ Phone Number _____
City State Zip

Have you participated in this program prior to this year? Yes _____ No _____

What is your anticipated medical school graduation date? _____

Are you willing to enter a primary care residency upon graduation and practice primary care in a Kansas county other than Douglas, Johnson, Shawnee, and Sedgwick upon completion of residency? Yes _____ No _____

Indicate the amount of monthly stipend you would like to receive if selected as a recipient. \$ _____ (\$1,500 maximum)

Signature of Applicant _____ Date _____

Permanent Mailing Address _____
City State County Zip

In what county were you born? _____ State _____
Please note – COUNTY, not country

Name of the high school from which you graduated _____
High School County State

To Be Completed by the Registrar

CERTIFICATION

The above-named applicant for Kansas Medical Student Loan has been accepted or is enrolled at the University of Kansas School of Medicine as a full-time student in a program leading to the degree of Doctor of Medicine.

Registrar _____ Amount of Loan

A. Tuition _____

B. Stipend _____

C. Total _____

Office Use Only/Date Stamp