

**RENEWAL APPLICATION  
FOR KANSAS MEDICAL STUDENT  
LOAN PROGRAM**

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

**SCHOOL YEAR 2007-2008**

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

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1. Name of Applicant \_\_\_\_\_
  2. Social Security Number \_\_\_\_\_ KUMC Student ID: (7 digit) \_\_\_\_\_
  3. Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
  4. Present Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
  5. Present Phone Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
  6. Permanent Mailing Address \_\_\_\_\_
  7. Classification for fee purposes: legal resident of Kansas \_\_\_\_\_ nonresident \_\_\_\_\_
  8. Have you participated in this program prior to this year? Yes \_\_\_\_\_ No \_\_\_\_\_
  9. What is your anticipated medical school graduation date? \_\_\_\_\_
  10. 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 \_\_\_\_\_
  11. Indicate the amount of monthly stipend you would like to receive if selected as a recipient \$ \_\_\_\_\_ (\$1,500 maximum)

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

\_\_\_\_\_  
Date

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**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.

Amount of Loan

\_\_\_\_\_  
Registrar

A. Tuition \_\_\_\_\_

B. Stipend \_\_\_\_\_

C. Total \_\_\_\_\_

Office Use Only/Date Stamp