



BAY REGION

Complete and mail application to address below. Include all required enclosures and attachments.

MEDICAL STUDENT GRANT APPLICATION

PERSONAL

Last Name: _____ First Name: _____ Middle Name: _____

Contact Address	Apt#	City	State	ZIP Code
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Permanent Mailing Address	Apt#	City	State	ZIP Code
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E-Mail Address: _____

Telephone Number(s):

Home	Work	Cell
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Best time to call: _____ May we contact you at work? ☐ Yes ☐ No

Are you 18 years old or older? ☐ Yes ☐ No Are you a U.S. Citizen? ☐ Yes ☐ No

Social Security Number: _____ - _____ - _____

EDUCATION

	Name and Location	# of Years	Diploma & Degree	Courses of Study
College	_____	_____	_____	_____
Graduate School	_____	_____	_____	_____
Medical School	_____	_____	_____	_____

Are you currently licensed? ☐ Yes ☐ No

If, yes: In Michigan? ☐ Yes ☐ No Number: _____ Exp Date: _____

Any other state? _____ Number: _____ Exp Date: _____

Mail to: Jason M. White, MD, Chief Medical Officer • McLaren Bay Region • 1900 Columbus Avenue, Bay City, MI 48708

MILITARY

Have you had any experience in the Armed Forces of the United States? ☐ Yes ☐ No

If yes, what branch? _____

Discharge Date: _____ Rank at discharge: _____

Type of Discharge received: _____

Are you in the reserves? ☐ Yes ☐ No If yes, date obligation ends: _____

HEALTH

Do you have any contagious or communicable diseases that are a direct threat to the health or safety of others in the workplace? ☐ Yes ☐ No (If yes, explain on separate sheet.)

PROFESSIONAL INFORMATION

Type of residency planned:

☐ Family Medicine ☐ Pediatrics ☐ General Internal Medicine ☐ Obstetrics

Anticipated date of beginning residency: _____

ADDITIONAL INFORMATION

Have you ever been convicted of a crime other than a minor traffic violation? ☐ Yes ☐ No

If yes, when, where, and nature of the offense: _____

SUPPORTING INFORMATION

Please submit the following materials to complete your application:

1. Personal statement discussing choice of specialty, interest in the Bay City area (including mention of any personal ties to the area), reasons applying to this program, and plans for practice after residency.
2. Four (4) letters of recommendation, including one (1) from your medical school dean, two (2) from clinical preceptors, and (1) personal reference. Letters of recommendation must be sent directly from the author under separate cover to: Jason M. White, MD, Chief Medical Officer; McLaren Bay Region; 1900 Columbus Ave., Bay City, MI 48708
3. Copy of medical school transcripts.
4. Curriculum Vitae, including volunteer experience.

I attest that the information I have provided in this application is accurate and truthful to the best of my knowledge.

Signature

Please Print Name

Date