



COMMUNITY FOUNDATION of the OZARKS

Dr. William M. Walker Memorial Medical Scholarship 2008

The Walker Scholarship provides funds to assist a medical student. One \$2,300.00 scholarship will be awarded for the 2008-09 academic year.

Eligibility Criteria

- Must be medical student enrolled in accredited medical school in Missouri or Iowa
- Must be entering final year of medical school
- Must be natural-born US citizen
- Must be developing superior clinical skills, and have demonstrated ability to communicate with patients effectively/with empathy
- Top 15% of class
- Preference given to Veterans; if credentials equal, special consideration to US Marine

Checklist - a complete application includes:

- A completed CFO-Selected Scholarship Application Form
- A completed Walker Scholarship Application Form
- An original copy of your Medical School transcript with cumulative GPA
- If military, documentation of your service record
- Two letters of recommendation from professor(s) and/or Dean

DEADLINE

Your application must be received by **June 27, 2008**

Please fill in all information as requested. An incomplete application may be disqualified.

Please mail application and all required support materials in ONE envelope to:

Gay Lynn Russell, Scholarship Coordinator
Community Foundation of the Ozarks
425 E Trafficway, Springfield MO 65806

For questions contact Gay Lynn Russell at (417) 864-6199 or grussell@cfozarks.org



COMMUNITY FOUNDATION of the OZARKS
CFO Committee-Selected Scholarship Application

Scholarship you are applying for _____

Name _____ (please print) Last 4 digits
of Soc Sec # _____

E-Mail _____ Cell phone _____

Address _____
Street

_____ City St Zip

Home Phone _____ Parent's name _____

High School attended _____

Undergraduate college _____

Include official copy of your college transcript with cumulative GPA

Applicant's signature _____ Date _____

DEADLINE: June 27, 2008



COMMUNITY FOUNDATION of the OZARKS

**Dr. William M. Walker Memorial Medical Scholarship
Application**

Name _____ Date _____
(please print)

School Address _____

City _____ St _____ ZIP _____

Name of School of Medicine _____

Are you a Veteran? Yes No Branch of Service _____

Include documentation of your service record

Include an original copy of your Medical School transcript w/cumulative GPA

Class Rank _____ GPA _____

Include two letters of recommendation from professor(s) and/or Dean;
addressing the direction of your focus – i.e. research, whole patient care,
specialty, etc

DEADLINE: June 27, 2008

