

Dr. Wilson Hudson Turner and Sara Elizabeth Turner Medical Scholarship Application 2025

DEMOGRAPHIC INFORMATION

Name _____
Last First Middle

Permanent Address _____

School Address _____

Home Phone _____ Cell Phone _____

DOB ____ / ____ / ____ SS# xxx-xx - _____ email _____

ACADEMIC INFORMATION

High School _____ Graduation Date _____

ACT / SAT _____ GPA _____

College / University _____ Graduation Date _____

MCAT _____ GPA _____

College Address _____

Medical College / University _____

Expected Graduation Date _____

Medical College Address _____

WORK HISTORY

Additional pages may be attached

Job Title _____

Place of Employment _____

Dates of Employment _____

Name of Supervisor _____

Supervisor's Phone Number _____

Briefly describe your duties _____

Job Title _____

Place of Employment _____

Dates of Employment _____

Name of Supervisor _____

Supervisor's Phone Number _____

Briefly describe your duties _____

Job Title _____

Place of Employment _____

Dates of Employment _____

Name of Supervisor _____

Supervisor's Phone Number _____

Briefly describe your duties. _____

VOLUNTEER EXPERIENCE

HONORS/AWARDS

☐ TRANSCRIPTS

An official transcript from all institutions listed

☐ ACADEMIC TESTING / SCORES

Copy of ACT or SAT- May be included on high school transcript.
MCAT – If applicable

☐ ESSAY

Using at least 250, but not more than 500 words, describe why you should receive the Turner Medical Scholarship.

☐ REFERENCES

Include at least two letters of reference from people who are not relatives

☐ FINANCIAL INFORMATION

1. A copy of an official Student Aid Report (not worksheet) from the Free Application for Student Aid (FAFSA) program. www.fafsa.ed.gov. If you are older than 26 years old and/or attending professional school, you must also submit Parents Income Tax returns (FAFSA will no longer allow you to add parental information). **All parental information is required. Failure to provide parental financial information will result in an incomplete application and not considered.**
2. The attached Financial Aid Information Request Form, signed by the Director of Financial Aid at the student's college or university.

I certify that the enclosed information is true and correct. All references and information provided may be verified. If selected, the Houston County Medical Society may use my name in association with the Dr. Wilson Hudson Turner and Sara Elizabeth Turner Medical Scholarship.

Applicant's Signature

Date

