ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Podiatric Scholarship Program Application
Academic Year 2019-2020
State Fiscal Year 2020

The application submission period is May 15, 2019 through June 30, 2019. Applications received prior to May 15, 2019 or after June 30, 2019 will not be accepted.

Name: ______________________________________________________________________

Mailing Address: ______________________________________________________________________

_______________________________________________________________________________
City    State    Zip Code

Phone: ____________ ____________ E-mail:  _____________________________
       Home   Cell

Date of Birth: _______________________  Gender:   _____ Male   _____ Female
               mm / dd/ yyyy

U.S. Citizen?   ___ Yes   ___ No   If no, are you a lawful permanent resident?   ___ Yes   ___ No

How many years have you resided in Illinois? ______________________________________

Ethnicity (required):

___ African-American (origins in any of the black racial groups in Africa)
___ Hispanic (origins in Mexico, South or Central America, or the Caribbean Islands)
___ Asian American (origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands)
___ White, non-Hispanic
___ Native American / Alaskan Native (origins in any of the original peoples of North America)
___ Other (specify) __________________________
Name and location of the Illinois podiatric medical school where you are enrolled or admitted:
______________________________________________________________________________

Anticipated graduation date? ____________  Current Grade Point Average: ___________

Do you have any obligations to provide health care services due to loans, scholarships, grants, or other commitments? If yes explain here:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please answer the following questions, limiting your answers to one typed, single spaced page per question. Sign the answer, then append your answers to the application.

1. Describe any experience you have had with medically underserved populations. Include experiences you initiated, as well as experiences gain through your schooling.

2. Describe any experience(s) that significantly influenced your choice of health care career.

3. Describe your career goals, including the type of practice and setting you want.

4. Describe any special circumstances regarding your financial status.
RELEASE / CERTIFICATION STATEMENTS

By placing my signature on the line below, I agree to and certify the following:

1. IDPH is authorized to verify all statements in this application. I hereby authorize all persons and all entities, including educational institutions, to provide any information known about me to IDPH.

2. I am not in default on any obligations for any previously received state or federal loan funds.

3. All information submitted in this application is true, complete, and accurate in all respects.

4. Any educational institution which I attend is authorized to release all information requested by IDPH relevant to my grades, academic standing, and financial status.

5. If I receive a scholarship, I agree to practice on a full-time clinical basis at a medical facility in a Health Professional Shortage Area in Illinois as a podiatric physician. My practice will begin within 30 days after completion of a podiatric medical residency and licensure to practice podiatric medicine in Illinois. I will practice one full year (or portion thereof if I receive a partial scholarship) for each year of scholarship assistance I receive from IDPH.

6. I default on the scholarship if I fail to: 1) complete podiatric medical school, 2) become licensed as a podiatrist in Illinois, or 3) fulfill the required service obligation. Should I default, I agree to repay to IDPH three times the amount of the annual scholarship grant for each year I attended podiatric medical school.

Signature: ___________________________________ Date: _________________
The application must and include the following:

1. Completed application form.

2. A copy of your birth certificate, or documentation that you are a naturalized citizen, or documentation that you are a lawful permanent resident of the U.S.

3. A copy of your 2019-2020 Student Aid Report from your FAFSA application.

4. Proof of enrollment or letter of acceptance into a podiatric medicine program located in Illinois. This letter is not needed if your official transcripts demonstrate you are currently enrolled in a podiatric medical program in Illinois.

5. Official transcripts from your undergraduate or podiatric school; transcripts must be received by IDPH directly from the school or have been issued to the applicant in a sealed envelope, which shall remain sealed until its arrival at IDPH; transcripts must include the institution's seal, the date the transcript was issued, and the registrar's signature; transcripts that do not conform to these requirements will not be accepted.

6. Completed narrative questions.

Send The Application and Supplemental Materials To:

Illinois Department of Public Health  
Center for Rural Health  
Podiatric Scholarship Program  
535 West Jefferson Street, Ground Floor  
Springfield, Illinois 62761-0001

IDPH recommends that you send your materials via certified mail or use United Parcel Service or Federal Express so that you can track your submission. IDPH is not responsible if the U.S. Postal Service or a private courier does not deliver application materials within the required time frame.