

SOROPTIMIST OF CAPE MAY COUNTY  
2023 MEDICAL AWARD APPLICATION

To qualify for this award the Applicant must demonstrate the following:

1. Female and Cape May County Resident
2. Dependability demonstrated by completing responsibilities honestly, reliably and with loyalty
3. Leadership proven by the ability to lead with initiative
4. Determination and commitment in pursuit of goals
5. Confirmation of current enrollment, acceptance or application to a medically related program

PART 1: PERSONAL INFORMATION

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE & ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PART 2: EDUCATION

List secondary schools attended or are currently enrolled in. As well, any medically related training received preparing you for a medical career.

School	Dates Attended	Major	Degree/Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PART 3: EDUCATIONAL GOALS

Name of College, University or Allied Health Program \_\_\_\_\_

Enrolled \_\_\_\_\_

Applied \_\_\_\_\_

Accepted \_\_\_\_\_

Approximate amount of time to complete education \_\_\_\_\_

PART 4: PERSONAL ESSAY

Attach a one-page typed essay, which includes your goals in your chosen field of study, any contributions in your community and why you are a good candidate for this award.

PART 5: REFERENCES

Attach 2 letters of character reference to this application

PART 6: AGREEMENT

I understand that my application and supporting information becomes the property of Soroptimist International of Cape May County and SICMC has discretionary authority in all matters relating to this award.

I certify the information in this application is complete and accurate to the best of my knowledge. If there are any changes, I will notify SICMC. I also certify that this is the only application I have submitted this year for this and any other Soroptimist Club.

Applicant

Signature \_\_\_\_\_ Date \_\_\_\_\_

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