Diversity in Medicine Scholarship
2019-2020 Application Cycle

Verification of Financial Need

INSTRUCTIONS

To complete this form:

- **Part 1 – APPLICANT:** Please complete and sign the waiver on the top portion of the form acknowledging that you are allowing AMSNY to receive information regarding your financial need.

- **Part 2 – CDMA REPRESENTATIVE:** Please have your medical school's AMSNY Committee on Diversity and Multicultural Affairs (CDMA) Representative complete the form with respect to your financial need. The CDMA Representative should submit the completed form in PDF format to scholarship@amsny.org by June 17, 2019.

  A contact list of all CDMA Representatives can be found on the AMSNY Diversity in Medicine Scholarship application webpage at https://amsny.org/initiatives/diversity-in-medicine/diversity-programs/diversity-in-medicine-scholarship/.

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STUDENT WAIVER

I hereby waive my rights under the Family Educational Rights and Privacy Act of 1974 (FERPA)

and I grant permission for ____ to release
(school for 2018-2019 academic year)
academic and ethical/honor board information, and information about financial aid, to the Associated Medical Schools of New York for the purposes of application for the Diversity in Medicine Scholarship.

____
Student First and Last Name

____ ____________________
Student Signature **Date**

FINANCIAL NEED

I certify that the Office of Financial Aid at ____
(school for 2018-2019 academic year)
has documented that ____:
(first and last name of student)

__ **qualifies** for need-based financial aid at our institution.

__ **does not qualify** for need-based financial aid at our institution.

____
AMSNY CDMA Representative First and Last Name

____ ____________________
AMSNY CDMA Representative Signature **Date**

The AMSNY CDMA representative should email this completed form in PDF format to scholarship@amsny.org by June 17, 2019.