



www.fmec.net

**THE 2009 NORTHEAST REGION MEETING**  
Of the  
**SOCIETY OF TEACHERS OF FAMILY MEDICINE**  
**October 30 – Nov. 1, 2009**  
**The Hilton Rye Town Hotel**  
**Rye Brook, NY**

**MEDICAL STUDENT SCHOLARSHIP APPLICATION FORM**

A scholarship includes tuition, meals and overnight accommodations at the Hilton Rye Town Hotel in Rye Brook, NY. Students will share a hotel room with two or three students per room. If you prefer to share a room with a particular individual, please indicate the person's name below. Please complete and return the following to the address below. A letter indicating your receipt of a scholarship will be sent after this registration form has been processed. For additional information, contact Laurence Bauer, MSW (937) 428-7866. [Laurence.bauer@sbcglobal.net](mailto:Laurence.bauer@sbcglobal.net) [www.fmec.net](http://www.fmec.net)

**PLEASE PRINT:**

**Students Name** \_\_\_\_\_ **SEX** Male Female  
(Circle)

**Medical School** \_\_\_\_\_

**Student's Class in Medical School** (circle one) First Year Second Year Third Year Fourth Year

**PLEASE PRINT:**

**Mailing Address** \_\_\_\_\_

City State Zip

**Telephone** \_\_\_\_\_ **FAX** (if available) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**E-mail Address** \_\_\_\_\_ (Please print neatly)

**Hotel Accommodation** I will need a hotel room on (check one) \_\_\_\_\_ Friday Only  
\_\_\_\_\_ Friday and Saturday  
\_\_\_\_\_ Saturday only  
\_\_\_\_\_ I will not need a Hotel Room

I prefer to share a hotel room with \_\_\_\_\_ (Name)

I would like to request vegetarian meals: \_\_\_ Yes \_\_\_ No (deadline to request Vegetarian meals is Oct. 15<sup>th</sup>)

Are you a member of the American Academy of Family Physicians? \_\_\_ Yes \_\_\_ No

Are you a member of your State's Academy of Family Physicians? \_\_\_ Yes \_\_\_ No

For funding purposes only, are you a member of a minority group? \_\_\_ Yes \_\_\_ No

May we share your mailing address with Residency Directors in the Northeast Region? \_\_\_ Yes \_\_\_ No

There are a limited number of scholarships available for each medical school. Where possible, obtain the signature of your Family Medicine Predoctoral/Clerkship Director or a Family Practice Residency Director to indicate his/her support for your scholarship request.

\_\_\_\_\_  
(Signature)

Mail the completed form to:

Or **FAX the completed form to: 360-285-2562**

Ms. Jennifer Stamper

2009 STFM: NE Region Meeting • 312 Lewiston Road • Kettering, OH 45429 • Phone: 937-643-3455 (Rev. 5/07/09)