



AMERICAN  
ASSOCIATION FOR WOMEN  
PODIATRISTS, INC.

FOUNDER'S SCHOLARSHIP APPLICATION

Deadline June 1, 2009 (must be RECEIVED by this date)

Up to 5 scholarships of \$1000 are awarded.

Send this form and transcript to:

Dr. Erika Schwartz  
909 Northwest Drive  
Silver Spring, MD 20901

**Applicant Information**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Phone: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Are you a member of the AAWP (REQUIRED)? YES  NO  Do you have a GPA > 3.0 (REQUIRED)? YES  NO

Are you currently a 3<sup>rd</sup> year student (REQUIRED)? YES  NO

**Education**

College: \_\_\_\_\_ Address: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? YES  NO  Degree: \_\_\_\_\_

Podiatry School: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

**Reference**

*Please list a professional reference.*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

**AAWP Positions and Involvement**

## Disclaimer and Signature

*I certify that my answers are true and complete to the best of my knowledge.*

*If this application leads to the award of a scholarship, false or misleading information in my application or interview may result in my release of monies granted.*

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

Send an official transcript from your podiatric medical school.

Please include a personal statement below to support your request for an AAWP Founder's Scholarship.