

PHYSICIAN MANPOWER TRAINING COMMISSION
Family Practice Resident Rural Scholarship Program

APPLICATION

Name _____ M.D. or D.O. SS# _____
(First, Middle, Last) (select one)

Medical License Number(s) List All _____ Maiden Name _____

Do you have now, or have you ever had a restricted license? ___ Yes ___ No (If yes, please explain)

Address _____
(Street/P.O. Box, City, State and Zip) (E-mail address)

Phone Number () _____ Cell Number () _____

Birth Date ___/___/___ Hometown _____ Marital Status _____

Spouse Name _____ Maiden Name _____ SS# _____

Spouse Occupation _____ Spouse Hometown _____

Number of Children _____ Ages _____

Applicant: Parents' Name, Address and Phone _____

Medical College(s), City and State _____ Dates Attended _____

Family Practice/General Practice Training Institution, City and State _____ Dates Attended _____

Family Practice/General Practice Residency Level ___ 1st year ___ 2nd year ___ 3rd year

Anticipated Date of Completion (Mo/Yr) _____

In what extra-curricular activities (community, hobbies) have you participated while in medical school and/or postgraduate training?

**Family Practice Resident Rural Scholarship Program Application
Continued**

Do you know a rural community that will sponsor you? Yes No

If yes, name of town _____

List, in order of preference, the rural communities or areas in which you prefer to practice:

1) _____

2) _____

3) _____

Explain your community/state area choice:



Do you presently have any scholarships or loans which have a practice obligation?

Yes ___ No

If yes, please explain _____

Please read and initial each statement below:

I understand that participation in the PMTC Resident Rural Scholarship Program requires me to:

- Select and match with a community on or before the end of the second year of residency training _____ 
- Complete a one-month elective rotation in the matched community in third year of residency training _____ 

The Physician Manpower Training Commission is given permission to contact any parties or to obtain the sources of information, which it deems necessary to verify my eligibility for this scholarship/loan.

The Physician Manpower Training Commission, in compliance with Title VI of the Civil Rights Act of 1974 and Title IX of the Education Amendments of 1972 (Higher Education Act), does not discriminate on the basis of race, color, national origin or sex in any of its policies, practices, or procedures. This provision includes, but is not limited to, employment and financial services.

I hereby declare that the information contained in this application is true and correct to the best of my knowledge.

Signature of Applicant _____ 

Date of Application _____

***PLEASE INCLUDE A PICTURE WITH THIS APPLICATION**

Please return to:

**Physician Manpower Training Commission
119 North Robinson Avenue, Suite 520
Oklahoma City, Oklahoma 73102
(405) 604-0020 FAX (405) 768-2263**

3/10/2020