

Office of Admissions  
 IAU College of Medicine  
 5999 Summerside Dr Ste 220  
 Dallas, TX 75252  
 Ph : 972-484-9700

IAU College of Medicine Campus  
 Gable Woods South  
 Vieux Fort, St. Lucia  
 Ph : (758) 454- 3424



## Saint Lucian Scholarship Application

### GENERAL INSTRUCTIONS

- ❖ This scholarship is for citizens and residents of the Island of Saint Lucia only
- ❖ A personal essay and supporting documents establishing your eligibility MUST accompany this application.
- ❖ Mail applications to the US Office of Admissions at least 45 days prior to the start of classes.
- ❖ Questions about scholarships may be directed to the Associate Director of Admissions at 1-888-440-4474

### PERSONAL INFORMATION

Last Name		First Name		Middle Name	
Current Address		City	State	Zip Code	Country
Telephone #	Please indicate type <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cellular		Social Security No and/or Passport No.		
Term of Enrollment	Student Status <input type="checkbox"/> 6yr MD <input type="checkbox"/> 4yr MD		Email :		

### EDUCATIONAL HISTORY

*List the most recent institution first.*

Name of School and Address	From Mo/Yr	To Mo/Yr	Major/Minor	Did You Graduate?	GPA
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

### AWARDS AND ACHEIVEMENTS

Please list all relevant awards, memberships, voluntary activities, certifications.

Type	State	Duration	Remarks

**PROFESSIONAL EXPERIENCE***List any recent positions you have held.*

Institution Name & Address				Phone	
From Month    Year		To Month    Year		Title	
				Responsibilities Held	
Institution Name & Address				Phone	
From Month    Year		To Month    Year		Title	
				Responsibilities Held	

**PERSONAL REFERENCES**

List at least three (3) references. University officials may contact these references.

Name and Position	Address	Telephone No.

I hereby certify that the information in this application is complete and correct to the best of my knowledge and belief; that the omission of information or submission of false information will void my application for scholarship. I understand that any offer of scholarship tendered to me is contingent upon my maintenance of passing grades in each course work that I attempt and my continued status of good standing in compliance with the rules and regulations of the International American University College of Medicine.

SIGNATURE OF APPLICANT: \_\_\_\_\_

DATE: \_\_\_\_\_

**RELEASE AUTHORIZATION**

I authorize International American University College of Medicine to obtain any information relating to my activities from current and previous professional and education institutions. This information may include any achievement, performance, attendance, disciplinary actions and/or educational-related issues. I release any and all individuals from all liability for damages that may result to me on account of compliance with this authorization.

PRINTED NAME OF APPLICANT: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

DATE: \_\_\_\_\_

❖❖❖❖❖❖❖❖❖ **FOR USE BY THE OFFICE OF ADMISSIONS ONLY** ❖❖❖❖❖❖❖❖❖

Student #	Term	Status	Starting Date	
Scholarship Offered	Duration:	Program of study: <input type="checkbox"/> 6yr MD <input type="checkbox"/> 4yr MD <input type="checkbox"/> Premed <input type="checkbox"/> Basic Sciences <input type="checkbox"/> Clinic		
Reviewed by	Date:	Approve: <input type="checkbox"/> Yes <input type="checkbox"/> No	Send regret Letter: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Interviewed by	Date:	Approve: <input type="checkbox"/> Yes <input type="checkbox"/> No	Send regret letter: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Authorized Signature		Date:		

*Please Note: Applications will not be considered complete until all required materials have been received. Only one scholarship will be awarded per student per semester.*