The Factor One Source Pharmacy Scholarship Application: 2017

Factor One Source Pharmacy will begin accepting submissions in May of 2017 for the upcoming school year. Applicants are not required to be patients of FOSRx, but must be residents of the United States of America.

All submissions are to be sent to **contact@fosrxfast.com** in one email, preferably in one combined attachment by June 30, 2017. Applications will be reviewed by committee during the summer, and notified of results in August. All applicants are subject to follow up questions during the selection process if the committee sees fit. References may/may not be called during that time as well. Winners will be sent checks immediately after all follow-up scholarship requirements have been met.

Platinum $5,000:

Must be affected by a bleeding disorder
Must have a declared major in a medical/pharmacy field.
Must have 3.8 GPA or higher to apply.
Preference given to those interested in science, healthcare, medical, and pharmacy fields.
Looking for outstanding students with a variety of talents and extracurricular interests.

Gold $2,500:

Must be affected by a bleeding disorder.
Must have 3.5 GPA or higher to apply.
Preference given to those interested in science, healthcare, medical, and pharmacy fields.
Looking for outstanding students with a variety of talents and extracurricular interests.

Silver $1,000:

Must be affected by any complex or chronic condition treated by FOSRx.
Must have a 3.0 GPA or higher to apply.
Looking for outstanding students with a variety of talents and extracurricular interests.

Complete Submissions Include:

- Application
- Photograph of applicant (must own copyright)

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Which Scholarship* Are You Applying For (Platinum, Gold, or Silver)?

*Please note that if you are not eligible for scholarship tier you apply for, your application will be dismissed during the process without further review. Only select one.

Full Name:	**Email:**
Mailing Address:	**Qualifying medical condition(s):**
Phone Number:	**Date of Birth:**
Cumulative GPA (on 4.0 scale):	**Name of college/university attending:**
Has completed (check all that apply): ☐ High school/GED equivalent ☐ 1 or more years of college ☐ Associate's Degree ☐ Bachelor's Degree ☐ 1 or more years of graduate school	**Work experience, qualifications:**
List hobbies, interests, passions:	**List any academic honors, awards, etc.:**
List declared major and minor:	**Where did you learn about this scholarship?**
Reference #1 (include name, relationship, and phone number):	**Reference #2** (include name, relationship and phone number):

Help us get to know you better. Please tell us (in no more than 500 words) relevant information about who you are in the box below. Examples: how your diagnosis has impacted your life, how you serve your community, how this scholarship will benefit you, what are your dreams and plans for the future, etc. In a nutshell, tell us your story.

Personal Essay:

APPLICANT AGREEMENT:

I hereby affirm that all the above stated information provided by me is true and correct to the best of my knowledge. I also consent that if chosen as a scholarship winner my picture may be taken and used to promote the FOSRx scholarship program. (Winner may waive photo due to unusual or compelling circumstances.) Winners will be asked to submit additional photos upon request, and with scholarship check.

I hereby understand that if chosen as a scholarship winner, according to the FOSRx Scholarship policy, it is my responsibility to use all scholarship funds toward furthering the education through private or public college/university listed above.

I hereby understand I will not submit this application without all required attachments and supporting information. Incomplete applications or applications that do not meet eligibility criteria will not be considered for this scholarship.

Signature of scholarship applicant: _____

Date: _____

STATEMENT BY PHYSICIAN

I hereby affirm that this application meets the criteria set forth by this scholarship program and that I support this application to FOSRx.

I hereby affirm that _____ (name of applicant) has been diagnosed with _____, and that I oversee this patient.

Signature of physician submitting the application: _____

Date: _____

Contact information (email and phone):_____

Clinic or hospital name:_____