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

Caribbean Medical Scholarship Application

GENERAL INSTRUCTIONS

- This scholarship is for citizens and residents of the Caribbean 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 ☐ Work ☐ Home ☐ Cellular	Social Security No and/or Passport No.
Term of Enrollment	Student Status ☐ 6yr MD ☐ 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
				☐Yes ☐No	
				☐Yes ☐No	
				☐Yes ☐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: ☐ 6yr MD ☐ 4yr MD ☐ Premed ☐ Basic Sciences ☐ Clinic	
Reviewed by	Date:	Approve: ☐ Yes ☐ No	Send regret Letter: ☐ Yes ☐ No
Interviewed by	Date:	Approve: ☐ Yes ☐ No	Send regret letter: ☐ Yes ☐ 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.