



Medical Student Visiting Clinical Scholars Program

Scholarship Application

Instructions for submission

Please complete this form and return it to the Duke School of Medicine, Office of Diversity & Inclusion via e-mail by saving a copy to your desktop and sending it as an attachment, along with your clerkship acceptance notification from the School of Medicine Registrar to odi@dm.duke.edu.

Name:

Last: _____ First: _____ MI: _____

Preferred Name _____

Email Address: _____

Gender: _____ Race: _____ Ethnicity: _____

Medical School: _____

Expected date of graduation from Medical School: _____

Medical Specialty/Area of Interest _____

What visiting elective(s) have you applied for _____

Contact information:

Mailing address: _____

Permanent address (if different from mailing address):

Home Phone: _____ Mobile Phone: _____

Emergency contact name and phone number:

Applicant signature: _____

Date of Application _____

Please address the following in 500 words or less:

What are your career aspirations and what do you hope to gain from your Duke experience?