



**CLARKSBURG LEAGUE FOR SERVICE, INC.
DR. A. ROBERT MARKS MEMORIAL SCHOLARSHIP APPLICATION**

TO QUALIFY FOR THIS SCHOLARSHIP YOU MUST:

1. Be pursuing a medical degree at the West Virginia University School of Medicine, Marshall University School of Medicine or West Virginia School of Osteopathic Medicine; and
2. Have graduated from a Harrison County high school or be a resident of Harrison County; and
3. Return application by March 31, 2022.

TO QUALIFY FOR THIS SCHOLARSHIP YOU MAY NOT BE THE CHILD, STEPCHILD, OR GRANDCHILD OF A PRESENT OR FORMER LEAGUE MEMBER EITHER LIVING OR DECEASED.

1. _____
(Full Name) (Date of Birth) (E-Mail Address)

2. _____
(Mailing Address) (Phone Number)

3. Guardian / Spouse Name _____

Guardian / Spouse Occupation _____

Guardian / Spouse Address _____

Guardian / Spouse Employer _____

4. List other dependent family members in the same household, their relationship to you, and their age(s) and indicate if they are employed full time or are college students.

5. State Medical School for which scholarship is requested. Accepted () Enrolled ()

(School)

6. Schools attended (ninth grade to present).

7. List any honors awarded in medical school.

8. List work experience.

(Employer)	(Phone)	(Position)	(Date)
(Employer)	(Phone)	(Position)	(Date)

9. List other scholarships, grants, and loans you are seeking or have been awarded.

(Source)	(Amount Sought)	(Amount Received)
(Source)	(Amount Sought)	(Amount Received)

10. Where do you expect to obtain funds for medical school? _____

11. List gross annual family income.

12. Please state any unusual family or personal circumstances you feel warrant the attention of the selection committee _____

13. Attach a one page typewritten statement (12 point font, single spaced) describing why you decided to attend medical school, any career aspirations you may have, and any other pertinent facts, which make you the best recipient of this scholarship.

14. Attach an official medical school grade transcript. Attach official undergraduate grade transcript if first year medical student.

15. Attach a recommendation or reference letter from the medical school you are attending.

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I further certify that I have carefully examined the eligibility requirements at the beginning of this application and satisfy all of the requirements.

(Signature)	(Date)
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Return your application and required information to: Donna Elsey, 141 Village Drive, Bridgeport, WV 26330. All applications must be postmarked or e-mailed by March 31, 2022.