MEDICINE CONNECT

# Sunrise Scholarship Application Form

2026–2027 Program • Deadline: June 30, 2027

## Applicant Information

Full Name: _____

Date of Birth: _____ Age: _____

Email: _____ Phone: _____

School / Institution: _____

Student Level: ☐ Middle School ☐ High School ☐ College ☐ Medical School

Expected Graduation Year: _____

Mailing Address: _____

## Scholarship Category

☐ Health & Medical Knowledge Communication ☐ Community Health Contribution ☐ Both

## A. Knowledge Communication Applicants

List eligible articles submitted to Medicine Connect and published or formally accepted for publication by Medicine Connect after completing the applicable review process. Articles published elsewhere do not earn Article Contribution Points unless they also complete the Medicine Connect submission and review process.

| Article Title | Date | Publication / Acceptance Status | Reviewer Rating (MC use) |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

Briefly describe the educational or community impact of your published work (readership, usefulness, engagement, sharing, audience served, or other evidence):

_____

_____

_____

## B. Community Health Contribution Applicants

List qualifying activities. Medicine Connect and non-Medicine Connect activities are equally eligible under the same substantive standards.

| Activity / Organization | Dates | Approx. Hours | Role / Actual Work | Impact / Result |
|---|---|---|---|---|

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| | | | | |

### Leadership & Initiative

Describe leadership responsibilities, initiatives, projects created or improved, teams coordinated, problems solved, and measurable results. Titles alone are not sufficient.

_____
_____
_____

### Consistency & Commitment

How long have you been meaningfully involved in community health/service? _____

Describe the continuity of your involvement and why you remained committed:

_____
_____

## Applicant Reflection

What did you do, why did you become involved, what did you learn, whom did you help, and what difference did your contribution make?

_____
_____
_____
_____

## Verification Contact (if applicable)

Name: _____ Organization: _____

Email / Phone: _____

## Applicant Certification

I certify that the information in this application is true and complete to the best of my knowledge. I understand that Medicine Connect may verify submitted information and that material falsification, plagiarism, or fraudulent documentation may result in disqualification.

Applicant Signature: _____ Date: _____

Submission Email: _____