University of Maryland **Student Emergency Fund Application**

School of Medicine

Name: UMB Student ID: Date:

Mailing Address: City: State: Zip:

Phone Number:

Email:

Requested Emergency Fund Amount (Maximum $600):

|  |  |
| --- | --- |
| **Cumulative GPA:** | **Expected Date of Graduation:** |
|  |  |

Please explain the following: Are you currently employed? If yes, please list your employer and hours you work each week. What kind of financial aid assistance are you receiving this year (ex. waivers, scholarships, loans, grants, etc)? Have you ever received any financial assistance from the School of Medicine?

|  |
| --- |
|  |

Please describe the nature of your financial crisis/emergency in detail. How is this emergency impacting your ability to be academically successful? Have you discussed your concerns with a university representative such as faculty, advisor, department chair, dean? What other community resources have your contacted?

|  |
| --- |
|  |

Please return the Student Emergency Fund Application to [scascio@som.umaryland.edu](mailto:scascio@som.umaryland.edu) along with **applicable supporting documentation or information (bills, receipts, legal notices).**

Please explain below how you became aware of the student emergency funding.

|  |
| --- |
|  |

Signature: Date: