UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE & DENTISTRY

FINANCIAL AID APPLICATION FOR 2017-2018: M.P.H., M.S. & Ph.D. Students

Name _____ SS# _____
Last First MI

Permanent Address _____

School Address_____

Home Telephone _____School Telephone_____ Department _____ Box # _____

E-mail Address _____

ACADEMIC INFORMATION

Expected Graduation Date (mm/dd/yy) _____ Degree Program _____

Unless you indicate otherwise, all Ph.D. candidates are assumed to be enrolled for a 12-month academic period and all MS and M.P.H. candidates for 9 months. Please indicate how many months you will be enrolled for the 17/18 academic period:

☐ 12 months ☐ 9 months ☐ Other (specify) _____

Enrollment Status - Number of credit hours: Fall 17 _____ Spring 18 _____ Summer 18_____

FINANCIAL INFORMATION

Indicate below the assistance which you anticipate receiving for the 17/18 academic year. This amount will be included as resource in determining your need for additional financial assistance.

1. Tuition Support from your Dept.: ☐ Full ☐ Partial ☐ None If partial, indicate amount: $ _____
2. Health Fee Coverage by your department: ☐ Full ☐ Partial ☐ None

University Health Insurance (Check one):

☐ I plan on waiving the Optional University Health Insurance because I am covered by other insurance.

Note: *You will need to formally waive the Optional University Health Insurance on University Health Service's website.*

☐ I plan on accepting the Optional University Health Insurance for the 2017-2018 Academic Year.

Indicate below the assistance that you are applying for:

☐ Federal Stafford Loans ☐ Federal Work-study ☐ Other

APPLICATION DOCUMENTS REQUIRED

☐ Submit a University of Rochester Financial Aid Application.

☐ Submit a FAFSA (Free Application for Federal Student Aid). Approximate submission date: _____

FEDERAL STAFFORD LOANS

First time SMD borrowers eligible for Federal Stafford loans will receive instructions on signing a promissory note from the Financial Aid Office.

To the best of my knowledge, I affirm that the information submitted on this form and all other financial aid forms is accurate, true, and complete. Furthermore, I agree to notify the Financial Aid Office of the School of Medicine and Dentistry of any change affecting my/our financial status during the 2017-2018 academic year.

Signature: _____ ***Date:*** _____

Submit to: Financial Aid Office, University of Rochester School of Medicine & Dentistry
601 Elmwood Avenue - Box 601, Rochester, NY 14642-0001