## Contact Information

|  |  |  |
| --- | --- | --- |
| Name |  | |
| Current Street Address |  | |
| City ST Zip Code |  | |
| Mobile Phone |  | Text: yes no |
| Email |  | |
| Preferred method of contact (circle one): email phone text by phone | | |

## Residency Program Information

|  |  |
| --- | --- |
| Residency Program |  |
| Year in Residency (i.e. PGY2) |  |

## Application Information

### Please select which set of Committee Meetings you attended during the 2016-17 Calendar Year (at least 50% attended is required):

|  |
| --- |
| August 2016 at Symposium by the Sea 2016 \_\_\_ May 2017 at FCEP Offices |
| November 2016 at FCEP Offices |
| February 2017 at FCEP Offices |
| Emergency Medicine Days 2017 |
| \*Please note that verification of your attendance will be cross reference on meeting sign-in/minutes. |
|  |
| Please select which of the FCEP conferences below you attended during the 2016-17 Calendar Year (at least 50% attended is required): |
| \_\_\_ Symposium by the Sea 2016 |
| Emergency Medicine Days 2017 |
| \*Please note that verification of your attendance will be cross reference on registration reports. |
|  |
| Name of the FCEP/EMRAF program or project that you participated in: |
|  |
|  |
| Please describe your involvement with the program/project and what you did. If additional space is required please submit description separately: |
|  |
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## Agreement and Signature

### I attest that the information submitted in this application is true and that I have attended and participated in the events/programs indicated above. I understand should I be awarded the EMRAF Scholarship that it is only to be used toward registration/travel expenses of any FCEP or ACEP conference/program or educational experience. I agree to allow FCEP to contact me regarding my application.

|  |  |
| --- | --- |
| Name (printed) |  |
| Signature |  |
| Date |  |

|  |  |
| --- | --- |
| OFFICE USE ONLY | Date Received: |
|  | Date Reviewed: |
|  | Decision: |