

**DIETETIC INTERNSHIP PROGRAM**

**SCHOLARSHIP APPLICATION  
2009-2010 ACADEMIC YEAR**

**1. Personal Data:**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial) (Credentials, if applicable)

Present Address: \_\_\_\_\_  
(Number/Street)

\_\_\_\_\_  
(City) (State) (Zip code)

Present Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Present E-mail Address: \_\_\_\_\_

Permanent Address (if different from above): \_\_\_\_\_  
(Number/Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

Permanent Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Permanent E-mail Address: \_\_\_\_\_

**Please indicate which E-mail address scholarship notification is to be sent to:**

**Present**       **Permanent**

Citizen or Permanent Resident of the United States?     YES     NO

Indicate the state where you are a legal resident: \_\_\_\_\_ Number of Years: \_\_\_\_\_

**2. Academic/Professional Data:**

Are you a member of the American Dietetic Association?     YES     NO

If yes, please provide membership number: \_\_\_\_\_

Are you a Dietetic Technician Registered?     YES     NO

If yes, please provide membership number: \_\_\_\_\_

Do you have (or will you have completed prior to the initiation of the New York-Presbyterian Hospital Dietetic Internship Program) an **advanced** degree in nutrition or a related field?

YES     NO

If yes, please provide the degree, college/university and completion date, if applicable:

What are your career objectives in the field of nutrition and food service?

Rank your three major areas of interest from the following list:

- |  |   |
|--|---|
| <input type="checkbox"/> Clinical Dietetics            | <input type="checkbox"/> Medicine                       |
| <input type="checkbox"/> Food Science/Technology       | <input type="checkbox"/> Exercise Physiology            |
| <input type="checkbox"/> Food systems Management       | <input type="checkbox"/> Government Policy              |
| <input type="checkbox"/> Nutrition Education           | <input type="checkbox"/> School food service            |
| <input type="checkbox"/> Nutrition Science             | <input type="checkbox"/> Wellness                       |
| <input type="checkbox"/> Pediatric Nutrition           | <input type="checkbox"/> Gerontology                    |
| <input type="checkbox"/> Sports Nutrition              | <input type="checkbox"/> Health Services Administration |
| <input type="checkbox"/> Consultant- Health Care       | <input type="checkbox"/> Communications/PR              |
| <input type="checkbox"/> Consultant – Private Practice | <input type="checkbox"/> Information systems            |
| <input type="checkbox"/> Public Health nutrition       | <input type="checkbox"/> Research                       |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Business                       |
| <input type="checkbox"/> Education                     | <input type="checkbox"/> Other: _____                   |

1<sup>st</sup>.: \_\_\_\_\_ 2<sup>nd</sup>.: \_\_\_\_\_ 3<sup>rd</sup>.: \_\_\_\_\_

List all colleges and universities that you are or have attended starting with your current or most recent school (use a separate piece of paper if needed):

SCHOOL	LOCATION	MAJOR	DATES ATTENDED	DEGREE RECEIVED	GPA*

\*GPA must be based upon a 4.0 system or converted to a 4.0 system. If necessary, contact your school for assistance with conversion.

Please provide verification of GPA by obtaining your faculty advisor’s signature or by providing transcripts. Transcripts should be the original document with an embossed seal or “Issued to Student” with a colored stamp or signature. Do not send photocopies.

Faculty Advisor’s Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

List your paid and volunteer work experiences of three months duration or longer and not related to academic course work, required practicums or field experiences starting with your current or most recent experience (use a separate piece of paper if needed):

TITLE/RESPONSIBILITIES	EMPLOYER/LOCATION/ PHONE NUMBER	DATES

List your professional memberships and honors. Include organizations you belong to, offices held, committee activities, publications prepared (**include copies**), presentations and other major accomplishments (use a separate piece of paper if needed):

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**3. Financial Data:**

Number of people in your family: \_\_\_\_\_

Number in college or in other educational programs: \_\_\_\_\_ ; if family members or attending other educational programs, please specify:

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Adjusted gross family income from last tax year: \_\_\_\_\_

Are you receiving financial aid from other sources?  YES  NO

If yes, please specify source/amount: \_\_\_\_\_

Anticipated monthly income and monthly expenses during course of dietetic internship program (list below):

Monthly Income:

Monthly Expenses:

Housing: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Meals: \_\_\_\_\_

Transportation: \_\_\_\_\_

Other (specify): \_\_\_\_\_

**4. Letters of Reference:**

Please list three individuals (such as college professors, employers, volunteer supervisors etc...) who can attest to your level of personal and academic responsibility and whose letters are included in this application. If an individual wishes his/her reference to be confidential, ask the individual to seal an original and one copy in a separate envelope with his/her signature over the seal. This envelope must be given to you to submit in the application packet.

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

3. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**5. Scholarship Statement:**

In 200 words or less, please elaborate on your career objectives and why you feel that you should receive the NewYork-Presbyterian Hospital Dietetic Internship Scholarship:

**6. Certification:**

All of the information in this application is true and complete to the best of my knowledge.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

In submitting my application to the NewYork-Presbyterian Hospital Dietetic Internship Scholarship Committee, I understand and agree to the following:

- I am free to accept the award if I am selected.
- Barring unforeseen accident, I will continue my plans for study as indicated in the application.
- Should I withdraw or be terminated from the NewYork-Presbyterian Hospital Dietetic Internship Program, I will receive only that amount of scholarship funding prorated to the date of termination.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Submit Application to:**

**NewYork-Presbyterian Hospital  
Dietetic Internship Scholarship Committee  
c/o Elaine Rosenthal, MS, RD  
Dietetic Internship Program Administrator  
Department of Food & Nutrition  
525 East 68<sup>th</sup> Street  
New York, NY 10065**