2015 Indiana Health Care Foundation
AMDA Core Curriculum on Medical Direction in LTC Scholarship

The Indiana Health Care Foundation (IHCF) applauds individuals who are dedicated to advancing their career through continued education. IHCF is accepting scholarship applications from individuals pursuing educational training for Medical Director Certification. Medical Directors who practice in any setting or combination of settings across the long term care continuum, including skilled nursing facilities, assisted living, CCRCs, hospice and home care are encouraged to apply. Geriatric fellows in training who are considering the inclusion of medical direction in their practices will find this course a beneficial introduction to management requirements for LTC.

To be considered for an Indiana Health Care Foundation AMDA Core Curriculum on Medical Direction in LTC Scholarship, the applicant must meet the following criteria:

- Reside in Indiana
- Completion of a U.S. Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program, or a Canadian Royal College of Physicians and Surgeons or College of Family Physicians accredited post-graduate training program; or completion of relevant U.S. post-graduate training and successful attainment of U.S. state licensure to practice medicine.
- Hold a current, unrestricted, state license as a medical doctor (MD) or doctor of osteopathy (DO) in the U.S. or an equivalent license to practice medicine in Canada
- Spend a minimum of 8 hours/month in service as a medical director in a long term care setting
- Have a passion to work with the elderly or disabled populations
- Return a completed scholarship application with a photocopy of current IN medical license, two letters of recommendation (one must be from an employee at a long term care facility), and essay (should include, but not be limited to, your passion, experience, reason for wanting/need the scholarship, future career goals, and why you deserve to receive it) by August 28, 2015
- Agree to a personal interview in Indianapolis if and when requested by IHCF

Individuals related to a member of the IHCF Board of Directors are ineligible.

IMPORTANT NOTICE:
The Core Curriculum on Medical Direction on LTC, or its equivalent on long term care management, is required for all Certified Medical Director (CMD) candidates. This course is the foundation for certification as an AMDA CMD. Taking the course does not make you a CMD. There are other requirements to complete. For more information, contact the American Medical Directors Certification Program (AMDCP) at 410-992-3117.
The scholarship provides the cost of the course registration and does not include travel expenses.

This course will be held November 5-8 in Philadelphia Pennsylvania and includes Part I and Part II.

IHCF requires the above information to be submitted with the completed application and postmarked by August 28, 2015. Failure to provide all requested information will result in disqualification.

Disclaimer: Scholarship recipient’s request to take Part I and/or Part II on an alternative date must be discussed with and approved by the IHCF Board of Directors.

Completed application and all required materials must be mailed to the following address:
Indiana Health Care Foundation
Attn: Executive Director
One N. Capitol Ave., Suite 100, Indianapolis, IN 46204
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Individual scholarships will be awarded based upon the information provided by the applicant. Applicants must meet criteria as specified. Only scholarship recipients will be contacted on or before September 11, 2015 by IHCF.

Applicant Information (Please type or print in ink)

Name: ______________________________________________________________________________

(Last)                                           (First)                                       (Middle Initial)

Permanent address: ____________________________________________________________________

City: _____________________________    State:  _______     Zip Code:  ________________________

By checking the following, I verify that I am at least 18 years old. ☐

Daytime Phone: ___/___________      Evening Phone: ___/___________    Email:  ____  ______

Academic Information

Medical School: __________________________________________  __________________________

City, State: __________________________________________________________________________

Graduation Date: (mm/yy) ________ Degree Earned: _____________

College Attended: __________________________________________  __________________________

City, State: __________________________________________________________________________

Graduation Date: (mm/yy) ________ Degree Earned: _____________

Special Training/Awards/Volunteer Experience (additional pages accepted)

List any special training, awards and volunteer experience.

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
Complete Employment History (additional pages accepted)

Current Employer: ________________________________________________________________

Employer Address: ______________________________________________________________________

City: _____________________________ State: _______ Zip Code: ___________________________

Phone: ______ / ________________________ Fax: _______ / _________________________________

Present Position: ______________________________________________________________________

Date Started: __ __ __ __ __ __ __

Immediate Supervisor: __________________________________________________________________

Previous Employer: _____________________________________________________________________

Employer Address: _____________________________________________________________________

City: _____________________________ State: _______ Zip Code: ___________________________

Phone: ______ / ________________________ Date Started: ______ Date Ended: ___________

Position or Job Held: ___________________________________________________________________

Immediate Supervisor: __________________________________________________________________

Previous Employer: _____________________________________________________________________

Employer Address: _____________________________________________________________________

City: _____________________________ State: _______ Zip Code: ___________________________

Phone: ______ / ________________________ Date Started: ______ Date Ended: ___________

Position or Job Held: ___________________________________________________________________

Immediate Supervisor: __________________________________________________________________

Location of Medical Director Position: _____________________________________________________

Address: _______________________________________________________________________________

City: _____________________________ State: _______ Zip Code: ___________________________

Phone: ______ / ________________________ Date Started: ______ Date Ended: ___________

Administrator: ________________________________________________________________________
Essay Questions
On a separate page, please write an essay that covers each of the following points. Your essay should be typed. Please limit your response to 1000 words.

- Describe your healthcare and volunteer experience
- Describe your passion for the elderly or disabled populations and reason for wanting/need for the scholarship
- Describe your future career goals and why you deserve to receive the scholarship

References: (please list the two references whose letters of recommendation are attached) (one must be from an employee at a long term care facility)

Reference 1:
NAME: ____________________________________________________________________________________
TITLE: _____________________________________________________________________________________
RELATIONSHIP TO CANDIDATE: ________________________________________________________________

Reference 2:
NAME: ____________________________________________________________________________________
TITLE: _____________________________________________________________________________________
RELATIONSHIP TO CANDIDATE: ________________________________________________________________

Please ask references to submit to you a letter of reference to be attached to your application. The letter should be on the individual's company letterhead if appropriate and should describe why you would be a worthy recipient of an IHCF scholarship, addressing such areas as level of professionalism, sensitivity to people's needs, a known commitment to the elderly or to long-term care, and reflection of good service and advocacy skills.

This reference page, along with the two letters of recommendation, should be submitted with your completed application. Letters of recommendation sent without applications will not be considered.