Keck School of Medicine of USC

# REQUEST FOR PHYSICIAN'S AID FUNDING

Full Name: _____ Class: _____

Email Address: _____ Amount Requested: _____

Please explain the reason for the request and financial hardship:

If eligible for funding, I acknowledge that de-identified information about my request will be shared with the Physician's Aid Society in the annual report that must be submitted by the Keck School of Medicine.

**Must check one:** ☐ I accept ☐ I decline

Signature: _____ Date: _____

Return to **Office of Student Affairs**:
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Los Angeles, CA 90089-9020
Fax: (323) 442-2663
medstuaf@usc.edu