

DIMER PROGRAM

SUPPLEMENTARY APPLICATION FOR SIDNEY KIMMEL MEDICAL COLLEGE

Name _____

Last

First

Middle

Permanent Address: _____

Street

City

State

Zip Code

Parent, Guardian or Spouse, if Married:

Name: _____

Last

First

Middle

Permanent Address: _____

Street

City

State

Zip Code

STATEMENT OF RESIDENCY – MUST BE COMPLETED

- 1 Name and relationship of person who contributes to my support and is entitled to claim me as an exemption on federal income tax:

Name: _____ Relationship: _____

STATEMENTS 2 AND 3 MUST BE COMPLETED BY THE PERSON LISTED IN STATEMENT 1. IF THE APPLICANT IS FINANCIALLY INDEPENDENT, THEN THE APPLICANT SHOULD ANSWER.

2. I have maintained a domicile and continuous residence in Delaware from _____ to _____.
Month/day/year Month/day/year

3. The latest year for which I have filed a Delaware State Income Tax return is _____.

Type of return filed: _____ Resident _____ Nonresident

I plan to file a return for the current year: _____ Yes _____ No

I am a registered voter in the state of: _____

I am employed in the state of: _____

I certify that this residence status information is correct.

(To be signed by the person completing statements 2 through 3.)

Signature: _____ Date _____

UNDERGRADUATE COLLEGE

Name of College: _____ Location: _____

I hereby make application for acceptance to the Sidney Kimmel-Delaware Medical Education Program. I am a bona fide resident of the State of Delaware.

I certify that the information submitted in this application is complete and correct to the best of my knowledge.

Signature of Applicant: _____ Date _____