

**Stony Brook University**  
**School of Medicine**  
**Need Based Grant Application**  
**Financial Aid Transcript**

**Instructions:** Applicants must submit the financial aid transcript to document financial aid received at undergraduate and prior graduate institutions. The applicant should complete Section A and forward this to their prior institutions' financial aid office for completion. Completed forms should be mailed to: Stony Brook School of Medicine, Office of Student Affairs, HSC Level 4 Room 147, Stony Brook NY 11794-8436. Completed forms can be emailed to: [Diane.Piscitelli@stonybrookmedicine.edu](mailto:Diane.Piscitelli@stonybrookmedicine.edu)

**Section A: To be completed by the applicant**

Applicant's name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 (Last) (First) (MI)

SB SOM Entering year: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize the financial aid office at: \_\_\_\_\_ which I attended  
 (Name of School)

From \_\_\_\_\_ to \_\_\_\_\_, to provide the information requested in Section B to the Stony Brook University School of Medicine Office of Student Affairs.

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

**Section B: To be completed by the financial aid office**  
**A complete summary of federal and institutional aid received is required.**

The aid information requested cannot be provided because the student:

\_\_\_\_\_ Did not apply for aid \_\_\_\_\_ Was ineligible for aid

\_\_\_\_\_ Other: \_\_\_\_\_

<u>Sources of Assistance</u>	<u>Award Years and Amounts of Assistance</u>				
	<u>Year:</u>	<u>Year:</u>	<u>Year:</u>	<u>Year:</u>	<u>Year:</u>

Federal Perkins Loan

Federal Stafford – Subsidized

Federal Stafford – Unsubsidized

Other Loans

Federal Pell Grant

Federal SEOG

EOP/HEOP

State Grant

Institutional Grant

Award Years and Amounts of Assistance

Year:                      Year:                      Year:                      Year:                      Year:

**Other Grant/Scholarships  
(Identify)** \_\_\_\_\_

**Expected Family Contribution** \_\_\_\_\_

**Unmet Need** \_\_\_\_\_

**Name/title of administrator completing this form:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_                      **Email address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

Stony Brook University  
School of **Medicine**  
Need Based Grant Application  
*Parent/Spouse Information*

Applicant Name: \_\_\_\_\_ SB ID Number: \_\_\_\_\_

SB SOM Entering Year: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PARENTAL INFORMATION:**

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

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

\_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Birthplace: \_\_\_\_\_

U.S. Citizenship Status: \_\_\_\_\_ U.S. Citizenship Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Annual Gross Income: \_\_\_\_\_ Annual Gross Income: \_\_\_\_\_

Parents' Marital Status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Never Married \_\_\_\_\_

Number of siblings: \_\_\_\_\_ Number in college: \_\_\_\_\_

**APPLICANT SPOUSE INFORMATION**

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Address: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Gross Annual Income: \_\_\_\_\_  
(Name) (City/State)

Please list all dependents:

Name	Age	Relation	Currently in College (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

***Federal income tax (parents' and applicant/spouse) transcripts are required of all applicants for need based grants. Go to: <https://www.irs.gov/individuals/get-transcript>***

