Greene County Medical Center Auxiliary Scholarship

Applicant Information

Full Name: ______________________________ Date: ____/____/____
First *Last* *M.I.*

Permanent Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Email: ______________

Date of Birth: ____/____/____ Social Security No.: ______________ Student ID: ______________

Parent/Legal Guardian Information

Information below relates to applicant's parent(s) or legal guardian(s).

Name: ______________________________
First *Last*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Occupation: ______________

Name: ______________________________
First *Last*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Occupation: ______________

Education

High School: ______________ City: ______________

From: ____/____ To: ____/____ Did you graduate? YES ☐ NO ☐ If no, anticipated graduation date: ______________

Grade Point Average: ________ Diploma: ______________

If you are currently in high school, what college do you plan to attend? ______________

College: ______________ City: ______________

From: ____/____ To: ____/____ Did you graduate? YES ☐ NO ☐ If no, anticipated graduation date: ______________

Grade Point Average: ________ Student ID #: ________ Degree: ______________

Employment

Are you currently employed? YES ☐ NO ☐ If yes, where are you currently working? ______________________

Start Date: ____/____ Hours per Week: __________ Do you plan to work during the academic year? YES ☐ NO ☐

Additional Information

What area of healthcare are you interested in, and why? ______________________

List your academic honors, awards and membership activities: ______________________

List your community service activities, hobbies, outside interests, and extracurricular activities: ______________________

Why do you need this scholarship? ______________________

Financial Information

Do you own a car? YES ☐ NO ☐

If you answered yes, what are your average monthly expenses for your car? ______________________

Please provide your estimated income and expenses below for the period which the scholarship is to be used.

This budget covers the period from __________ to __________ *Month/Year*

INCOME	AMOUNT
Current Savings	
Financial Assistance from Parents/Guardians	
Savings on Hand	
Other Scholarships Awarded	
TOTAL	

EXPENSES	AMOUNT
Tuition and Fees	
Room and Board	
Books and Supplies	
Miscellaneous *(entertainment, clothing, personal items, etc.)*	
TOTAL	

__________ - __________ = __________

Total Income **Total Expenses** **Total Needs**

References

Please provide three references who have known you for at least one year. *Do not include relatives or students*.

A letter of recommendation is required from each reference listed below. Reference letters can be submitted with the application, or sent directly to the medical center. *All reference letters must be submitted by the application deadline.*

Name: ______________________ ______________________
Last *First*

Address: ______________________ ______________________ __________ __________
Street *City* *State* *ZIP Code*

______________________ ______________________
Occupation *Years Known*

Name: ______________________ ______________________
Last *First*

Address: ______________________ ______________________ __________ __________
Street *City* *State* *ZIP Code*

______________________ ______________________
Occupation *Years Known*

Name: ______________________ ______________________
Last *First*

Address: ______________________ ______________________ __________ __________
Street *City* *State* *ZIP Code*

______________________ ______________________
Occupation *Years Known*

Applicant's Certification and Agreement

I certify that the foregoing information is true and correct, and I authorize the Auxiliary at Greene County Medical Center to make inquiries concerning me of any of the persons mentioned in this application, of the high school I attend and the college which I am attending or will be attending. *The Auxiliary Scholarship will be awarded without regard to race, color, sex, religion or age. Greene County Medical Center reserves the right not to process applications found to be incomplete as of the application deadline.*

Signature: ______________________________ Date:_____/_____/_____

For Medical Center Use Only

[Received On Stamp]

- ❑ Application Received by March 15
- ❑ Transcripts
- ❑ Copy of College Letter of Acceptance or other Proof of Enrollment
- ❑ Reference Letters (minimum of 3)
- ❑ Scheduled Interview

Interview Date: ______________ Interview Time: ______________