Greene County Medical Center
Foundation Healthcare 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: _____

Address of Financial Aid Office: _____
Street *City* *State* *ZIP Code*

Are you currently attending college? YES ☐ NO ☐ If yes, please fill out the questions below

If no, please continue to the Employment section of this application

Field of Education: _____

What is the duration of the educational program you are currently enrolled in? (Circle One):

2 years 3 years 4 years

What year of the educational program are you in currently? (Circle One):

1st year 2nd year 3rd year 4th year

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? _____

Please explain why you are applying for this scholarship *(If additional space is needed, please include on separate sheet of paper)*:

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 Foundation 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 Foundation Healthcare 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: _____
- ❑ Transcripts
- ❑ Copy of College Letter of Acceptance or other Proof of Enrollment
- ❑ Reference Letters (minimum of 3)