

MEMORIAL HEALTH CARE SYSTEM
AUXILIARY

Scholarship Application Form

The following data is requested in order to determine your eligibility for a scholarship award. Those eligible include individuals who are either a Memorial Health Care System current or past employee or a Memorial Health Care System current or past volunteer who plan to enroll a minimum of 6 course hours per academic semester. Please provide the requested information as listed below. Use additional paper if necessary. In addition, please provide three letters of recommendation. Your application should be returned to Memorial Auxiliary Scholarship Committee by March 30 for first semester and September 30 for second semester.

Date of Application: _____

Last Name	First Name	Middle	Maiden
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Current Address	City	State	Zip
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Phone Number	Phone for Message
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Current and/or Past Position at Memorial Health Care System: _____

Current and/or Past Volunteer Position at Memorial Health Care System: _____

Please complete the following.

1. Indicate the proposed area of study and the reason for selecting this area.

2. List name and location of institution for proposed study. Indicate either full time or part time. ***Please attach an official transcript from the institution you are attending.***

3. If you are currently receiving educational assistance (loans or scholarships) please state what kind and how much.

4. Indicate your future plans upon completion of program.

5. Please tell us why the Auxiliary should grant you a scholarship.

6. Please tell us on a separate sheet of paper why the Auxiliary should award you a scholarship and explain if there is a financial need.

7. Attach completed IRS W9 Form to application.